

# Open Research Online

---

The Open University's repository of research publications and other research outputs

## Ordering For Care And Caring For Order: Medical Power In English Prisons

### Thesis

#### How to cite:

Sim, Joe (1989). Ordering For Care And Caring For Order: Medical Power In English Prisons. PhD thesis The Open University.

For guidance on citations see [FAQs](#).

© 1989 The Author

Version: Version of Record

Link(s) to article on publisher's website:  
<http://dx.doi.org/doi:10.21954/ou.ro.000049e2>

---

Copyright and Moral Rights for the articles on this site are retained by the individual authors and/or other copyright owners. For more information on Open Research Online's data [policy](#) on reuse of materials please consult the policies page.

---

[oro.open.ac.uk](http://oro.open.ac.uk)

LX 96 + 26  
UNRESTRICTED

Ordering For Care And Caring For Order:

Medical Power In English Prisons.

Thesis submitted for the degree of  
Doctor of Philosophy

by

Joe Sim B.A., MSc.

Ordering number M7020131  
Submitted 7th Feb. 1989  
Approved 10th Feb. 1989

Faculty of Social Sciences  
The Open University

February 1989

## Abstract

This thesis is concerned with developing a sociological analysis of the history and consolidation of the medical service in English prisons. It covers the period 1774-1988 and explores a number of dimensions in relation to the Prison Medical Service (PMS) during this period. It challenges the notion of historical progression and benevolence which is often linked to an evolutionary view of medical development. An alternative theoretical perspective is proposed based on a critical reading of the work of Michel Foucault. This critical reading allows for the exploration of the relationship between medical discourse, discipline and regulation; the differential impact of medical power on women prisoners; the relationship between "less-eligibility" and the medical care of the confined; the resistance of prisoners to medical power; the inter-relationship between professional power and the English state. From this dialectical analysis, it is proposed that wider concerns around the regulation of the body and the normalisation of the mind were crucial determining factors in the consolidation of medical and psychiatric power in English prisons.

### III

#### Table of Contents

<u>Acknowledgements</u>	pages IV-V
<u>List of Tables</u>	page VI
<u>Post Examination Note</u>	page VII
<u>Frontpiece</u>	page VIII
<u>Chapter 1</u>	Analysing the Prison Medical Service: The Sociological Context pp.1-24
<u>Chapter 2</u>	The Organization and Role of the Contemporary Prison Medical Service pp.25-66
<u>Chapter 3</u>	Reconstructing the Mind, Disciplining the Body: Medical Power and the Criminal 1945-64 pp.67-208
<u>Chapter 4</u>	Medicine, Regulation and Control in the Penal System pp.209-321
<u>Chapter 5</u>	Medicine, Regulation and Control in the Twentieth Century: The Continuing Controversy pp.322-397
<u>Chapter 6</u>	At the Centre of the Professional Gaze: Women, Medicine and Confinement pp.398-517
<u>Chapter 7</u>	Uncovering Medical Power pp.518-536
<u>Chapter References</u>	pp.537-575
<u>Bibliography</u>	Primary Sources, Books and Articles pp.576-598



#### IV Acknowledgements

Over the last eight years, many people have contributed, in more ways than I can count, to the realisation of this thesis.

Thanks, then to the following: Gillian Hall, Susan O'Malley, Pete Beharrell, Tia Ballinger, Kristi Ballinger, Billie Sim, Tony Jefferson, David Hayden, Janet Johnson, Dave Macdonald, Tim Owen, Linda Quinn, Chris Powell, Michael Ignatieff, Victoria Greenwood, Paul Gordon, Pat Craddock, Dave Godwin, Ian Cameron, Mike Fitzgerald, Pete Archard, Ayesha Saleem, Phil Scraton, Sheila Scraton, Paul Gilroy, Vron Ware, Geoff Coggan, Anne-Marie Webster, Ricky Webster, Gareth Pierce, Mick Ryan, Tony Ward, Tillie Sim, Joe Sim, Teresa Sim, Penny Smith, Phil Thomas, Tony Bunyan, Paula Skidmore, Hilary Wilson, Catherine Hall. Thanks, additionally to Stuart Hall for his patience, good humour and intellectual support; to staff in the following libraries: Institute of Criminology, Cambridge; British Library; Prison Service Staff College Library, Wakefield; Liverpool Central Library especially Mark Urbanowicz; Liverpool University Medical Library; Liverpool Polytechnic Library; Public Record Office Kew Gardens; Home Office Library; Open University Library; Wellcome Institute for the History of Medicine; Gloucester Hospital Medical Library especially Helga Perry; to the students I have worked with on under-graduate courses at Liverpool Polytechnic and the post-graduate MA in Crime Deviance and Social Policy at Edge Hill College, Ormskirk; to colleagues at Liverpool Polytechnic, in particular, Peter MacMyler, John Hewitt, Tim Ashplant, Sandra Walklate, Pete Gill, Mike Brogden, Stan Meredith, Marion Price, Pauline Pasker, Phil Markey, Brenda Day, Lorraine Glover and Linda Halliwell; to Dave Llewellyn for the journeys

on the magic, swirling ship, and to Bob Dylan for chiming some freedom songs when the going got tough.

Finally, the thesis would never have been finished without the support, encouragement, technical skill and intellectual insights of Anette Ballinger. A sentence or two will never do justice to her contribution to the finished product. It shines through on every page.

List of Tables

<u>Chapter 2</u>	<u>Table 1</u>	Visits by Specialists to Prisons 1984/5 p.29
	<u>Table 2</u>	Number of Hospital Places for Pregnant Women p.30
	<u>Table 3</u>	Daily Average Number of Sick Treated in Prison Hospitals 1970-1980 p.34
	<u>Table 4</u>	Reports to Court by Prison Medical Officers 1984/5 p.51
	<u>Table 5</u>	Hospital Orders Without Restriction Order Under Section 60 of the 1959 Mental Health Act 1970-80 p.55
	<u>Table 6</u>	Hospital Orders With Restriction Order Under Section 60/5 of the Mental Health Act 1970-80 p.56
	<u>Table 7</u>	Removals from Prison to Psychiatric Hospitals 1970-80 p.58
<u>Chapter 4</u>	<u>Table 8</u>	Dietaries of County and Borough Gaols 1843 p.247
	<u>Table 9</u>	Deaths and Inquests 1848-63: Disposal of Bodies p. 260

22 October, 1990

M7020131

Dr J Sim  
School of Social Sciences  
Liverpool Polytechnic  
79 Tithebarne Street  
LIVERPOOL, L2

Dear Dr Sim

I write to confirm that the Higher Degrees Committee has accepted your examiners' recommendation, that your thesis should be deposited in the University Library without the passages identified as libellous by the publisher's solicitors.

They have, however, advised that the thesis must contain a note indicating the locations and length of the deletions.

I look forward to receiving your library copies and include a copy of our regulations on binding.

Yours sincerely

A handwritten signature in dark ink, appearing to read 'Anne Barrington', with a stylized flourish at the end.

Anne Barrington  
**Higher Degrees Officer**

Post Examination Note

Since this thesis was passed by the external examiners, it has been brought to my attention by a libel lawyer that some passages may be libellous. Consequently, with the authority of the external examiners and the Higher Degrees committee, these passages have been removed. They were located in the following places:

pp.210-235 (7900 words)

p.392 (382 words)

pp.399-401 (542 words)

p.412 (113 words)

pp.414-15 (143 words)

pp.420-423 (1193 words)

pp.540-1 (249 words).

## VIII

If there is an overall political issue around the prison, it is not therefore whether it is to be corrective or not; whether the judges, the psychiatrists or the sociologists are to exercise more power in it than the administrators or supervisors; it is not even whether we should have prison or something other than prison. At present, the problem lies rather in the steep rise in the use of these mechanisms of normalization and the wide-ranging powers which, through the proliferation of new disciplines, they bring with them.

Michel Foucault (1977)  
Discipline and Punish  
Penguin p.306.

## Chapter 1

### Analysing the Prison Medical Service:

#### The Sociological Context.

It is a subtle, erosive process. Almost every agency of education, social welfare and mental health talks the seductive language of prevention, diagnosis and treatment; and almost every client is a hostage to an exchange which trades momentary comfort and institutional peace for an indefinite future of maintenance and control (1).

This thesis is concerned with the origins, development and consolidation of medical power in English prisons. Until now, there has been no serious sociological study of the men and women who make up the medical service in the prisons of this country. Indeed, it was only in 1984 that the first book dealing with the service's role and practice was published (2). While critical of some aspects of its work, the book limited itself to a general overview of health care for the confined, rather than a specific analysis of why medicine takes the form that it does in prisons. In addressing this more specific sociological question, I have built on, and utilised the recent work of a number of writers in the area of prison history, most notably Michel Foucault. In this first chapter, I wish to outline and consider the different sociological dimensions arising from this earlier work which taken together provide the theoretical context for the analysis of the Prison Medical Service (P.M.S.) in English prisons. There are three dimensions, in particular, I wish to highlight. First, the use of a historical perspective to identify the continuities and dis-continuities in the relationship between medical power and the confined. Second, the issue of resistance to power and domination and the theoretical questions that derive from this. Finally, the question of power and its relevance to the emergence and consolidation of a discourse articulated by those who came to see themselves as a professional body of medical workers.



Prisons in History.

Until the late 1960s with the notable exception of Georg Rusche and Otto Kirkheimer's Punishment and Social Structure, published three decades earlier, the emergence and consolidation of prisons throughout Western Europe and North America was portrayed as a process of benevolent evolution, a movement from barbarism to enlightenment. This process was regarded as independent of wider structures of political economy, social class, ideology and power (3). However, at the end of the 1960s and throughout the 1970s and 1980s, the idea that prison regimes and philosophies had humanely and significantly progressed was severely jolted in the aftermath of a number of major and bloody disturbances in Europe and North America.

On 24th October 1969 there was a serious disturbance at Parkhurst on the Isle of Wight in the course of which 35 prison officers and 28 prisoners were injured (4). In November 1970, there was a strike at Folsom Prison in California. It was the longest and best supported in that state's penal history. For 19 days, 2,400 prisoners demonstrated their support for a 31 point prison manifesto that demanded a radical overhaul of the prison system (5). On August 21st 1971, George Jackson, the black revolutionary and author of the highly acclaimed Soledad Brother was shot dead in San Quentin California. It was said by the prison authorities that he and two other prisoners who died had been attempting to escape. Within a month, prisoners at Attica prison in New York State, deeply affected by Jackson's death, occupied 'D' Yard, and held it for three days. On 13th September, state troopers stormed the prison, retook the yard and shot dead 34 prisoners and 9 prison officer

hostages (6). Finally, in the summer of 1972, there were strikes at over 100 British prisons, a major disturbance at Peterhead maximum security prison in Scotland and at the end of the year another at Inverness Prison in the north of the country which resulted in one prison officer losing an eye. Four of those involved, who were serving life sentences, were given an extra six years (7).

This is not a complete list of the confrontations and disturbances that occurred in Western Europe and North American prisons at this time. Nonetheless, these events do illustrate the serious challenge that was emerging to the authority and legitimacy of the penal systems on both continents. It was a challenge which in North America at least was driven and fuelled by an increasing political consciousness especially among black prisoners who were making connections between struggles inside, and conflict outside of the walls (8). As Angela Davis wrote at the time:

Prisoners - especially Blacks, Chicanos and Puerto Ricans - are increasingly advancing the proposition that they are political prisoners. They contend that they are political prisoners in the sense that they are largely the victims of an oppressive politico-economic order, swiftly becoming conscious of the causes underlying their victimisation (9).

These upheavals within the prisons were related to the more general political and economic schisms that gripped Western capitalist democracies in the late 1960s. In Europe, these schisms crystallised around the moment of May 1968 and the demonstrations and uprisings in Paris. In North America, it was the increasing polari-

sation brought about by American involvement in South East Asia. Both influenced each other (10). These events had a profound impact on criminology fracturing the dominant positivist/labelling axis and laying the foundations for the emergence of the Marxist paradigm which was to be characterised as 'the new criminology' (11). They were also to have a significant impact on those academics interested in the development of institutions such as prisons and asylums. Their researches too were a challenge to the dominant evolutionary paradigm within which prisons up until then had been theorised.

In February 1971, the Groupe d'Information sur les Prisons (G.I.P.) was established in France. The group was committed to creating the conditions in which prisoners could not only speak for themselves but would also be heard. In other words, the G.I.P. challenged the traditional apparatus of secrecy that dominated the French penal system. It did this by supporting and publicising the struggles of prisoners particularly the 30 or so revolts that occurred in France in the winter of 1971-2. In relation to prison secrets, the group's ideas were quite clear, to break down the secrecy that was an essential element "of its normal functioning" and to create "the possibility for other kinds of discourse on prisons" (12). It was interested in mounting a "particular local attack on the social regime of truth which served to disrupt for a time the State apparatus of punishment" (13).

Michel Foucault was involved with the G.I.P. In April 1972, he visited Attica. In a subsequent interview with John Simon which was published in Telos in the spring of 1974 Foucault outlined the

ideas that were to be developed three years later with the publication of the seminal Discipline and Punish: The Birth of the Prison. In the interview he described Attica as a "machine" and took issue with the humanitarian idea that prisons were there to rehabilitate and reform the confined. Rather prisons were about discipline and elimination. Within the walls psychiatry played its part in this process:

..... Attica is a machine for elimination, a form of prodigious stomach, a kidney which consumes, destroys, breaks up and then rejects, and which consumes in order to eliminate what it has already eliminated. You remember that when we visited Attica they spoke to us about the four wings of the building, the four corridors, the four large corridors A, B, C, and D. Well, I learned again through the same former prisoner, that there is a fifth corridor which they didn't talk to us about; it's the corridor E. And you know which that one is?

Simon: No.

Foucault: Ah, Well, it is quite simply the machine of the machine, or rather the elimination of the elimination, elimination in the second degree; it's the psychiatric wing. That's where they send the ones who cannot even be integrated into the machine and whom the machinery cannot succeed in assimilating according to its norms, that it cannot crush in accordance with its own mechanical process. Thus they need an additional mechanism (14).

In 1978, the year after the publication of Discipline and Punish, Michael Ignatieff published A Just Measure of Pain. Again the book was a historical study and once more challenged the theory of benevolent reform as it had been applied by academics to the prison system in England in the years between 1750 and 1850. For Ignatieff, the philanthropy that reformers such as John Howard and Elizabeth

Fry were expressing was not simply a humane concern for the incarcerated but the yearning for "what they imagined to be a more stable, orderly and coherent social order ..... a new strategy of class relations" (15). In the preface to the book, Ignatieff set his analysis within what he termed the break-down of "the fragile order inside prisons" (16) which was followed by "nearly a decade of hostage-takings, demonstrations and full-scale uprisings. At first an American phenomenon, the prison revolt has spread to prisons in Spain, France, Canada, Britain and Italy" (17). Once more, Attica loomed large in his deliberations as an example of "the issue of the morality of state power in its starkest form" (18).

A third strand in critical work on prisons appeared in 1981 under the title of The Prison and the Factory. Originally written in 1977 by Dario Melossi and Massimo Pavarini, the book outlined what the authors saw as the functional connection between prisons and the capitalist mode of production. Put at its starkest, their thesis was based on the idea that the capitalist organisation of labour "shapes the form of the prisons as it does all other institutions ..... the only modifications are those required by the evolving exigencies of capitalism" (19). In the introduction to the book, the authors pointed once more to the fact that their initial interest in the history of the prison "was aroused during the late 1960s at a time when this institution in Italy (and elsewhere) was thrown into a deep crisis" (20).

For the purposes of the present study what was important about this body of work, despite the theoretical differences between the authors (21), was that each emphasised a historical perspective

that eschewed benevolent progression for more structural dimensions of political economy, social class, ideology and power.

Additionally, both Foucault and Ignatieff raised questions about the role of medicine and psychiatry in prisons and asylums. Once more, they moved beyond the idea that medicine had evolved as a set of benevolent practices and benign programmes which has been (and still is) the dominant view of institutional health care (22). For Foucault, the great reform movement in the asylums in the second half of the eighteenth century was not a sign of psychiatric progress but was better conceptualised as a "strange regression":

medicine engaged in the first instance with the subjects constituted in the space of exclusion not so much in order to differentiate crime from madness or evil from illness but rather to act as protector of those endangered by the 'permeable' walls of the houses of confinement ... the power to cure wielded by the doctor derived at root from the key structures of bourgeois society (23).

For Ignatieff, the introduction of medical personnel into prisons revolved around the issue of disciplining the confined, making their bodies and minds pliable to the new social order and class relationships of capitalism. In that sense, health care, bathing and medical inspection were not simply benevolent innovations but were part of the wider imposition of discipline and regulation.

This thesis picks up on the original insights of both Foucault and Ignatieff. In particular, the question of discipline, regulation and exclusion which they see as integral to the genesis of medicine in institutions is traced from the late eighteenth century to the

present. Such regulation is not simply based on the more obvious manifestations of discipline such as drugs, straitjackets or cellular confinement but also crystallises around how medical care itself developed within the disciplinary thrust of prison regimes. Throughout the nineteenth and into the twentieth century the discipline of less-eligibility underpinned penalty so that it was widely felt that prisoners could not and should not live and work in conditions superior to those outside the walls of the penitentiary. As Chapters 4 and 5 illustrate, ideologically prison medical workers were not free from these wider concerns nor indeed from the concerns that arose in relation to maintaining order internally behind the walls. In that sense, as both chapters indicate, the relationship between medicine and the confined was much more complex and contradictory than the evolutionary model of medical benevolence has hitherto recognized.

### Resisting Domination.

The question of resistance to medical power and its theoretical relationship to the wider sociological debates around class struggle, forms the second, central theme in this thesis. As different chapters will indicate men and women, both young and old, have, individually and collectively, raised serious questions about the health care of the confined and the role of medicine in controlling the behaviour of the ill-disciplined and recalcitrant. These protests have been supported, particularly through the twentieth century, by outside pressure groups who have called for significant and fundamental changes to be made in the management and work of the P.M.S.

This question of individual consciousness and resistance to domination has, within sociology, been part of the more general debate around the agency/structure dichotomy. Put at its simplest, this debate has crystalised around whether individual behaviour is determined by social forces beyond the individual's control or whether people shape their own lives through active social action, structures of symbolic meaning and role playing (24). This is not the place to consider the various nuances in this debate nor the finer epistemological and ontological points that flow from it. I do wish, however, to point to Barry Smart's arguments concerning the theoretical basis of sociology as a mechanism for understanding both human behaviour and social reality. In particular, he emphasises, "the dialectical nature of social reality and the importance of subjectivity" (25).

This contention has been reflected in the work of Marxists such as Antonio Gramsci who have argued for a sociological perspective that emphasises human voluntarism and subjectivity, historically constituted and dialectically related to the wider political economy of industrial capitalism. As Joseph Femia explains, Gramsci contended that effective human action was "the consequence neither of pure will, nor of inexorable forces but a particular kind of interaction between objective circumstances and the creative spirit of man" (26).

Such a perspective on the importance of consciousness and resistance within concrete political and material settings has formed the basis for a series of publications that have stressed the importance of collective and group action in the varieties of resistance that have developed unevenly in Britain from craftguilds, youth sub-



cultures, through to black people and the past and present women's movement (27). The point made below by John Clarke and others, while referring to the more general relationship between social classes, nonetheless, both sums up the thrust of these other studies and at the same time can be applied to the dynamic relationship involving the daily lives of prisoners and the immediate material environment within which they live:

Negotiation, resistance, struggle; the relations between a subordinate and a dominant culture, whenever they fall within this spectrum, are always intensely active, always oppositional, in a structural sense (even when this opposition is latent, or experienced simply as the normal state of affairs - what Gouldner called "normalised repression"). Their outcome is not given but made. The subordinate class brings to this 'theatre of struggle' a repertoire of strategies and responses - ways of coping as well as of resisting. Each strategy in the repertoire mobilises certain real material and social elements: it constructs these into the supports for the different ways the class lives and resists its continuing subordination. Not all the strategies are of equal weight: not all are potentially counter-hegemonic. Some may even be alternatives - e.g. working-class politics and certain kinds of working-class crime. We must also recognise that a developed and organised revolutionary working-class consciousness is only one, among many such possible responses, and a very special ruptural one at that. It has been misleading to try to measure the whole spectrum of strategies in the class in terms of this one ascribed form of consciousness, and to define everything else as a token of incorporation. This is to impose an abstract scheme on to a concrete historical reality. We must try to understand, instead, how, under what conditions, the class has been able to use its material and cultural 'raw materials' to construct a whole range of responses (28).

Historians, once more, have been pivotal in this development. In particular, the question of consciousness and resistance to domination has been tied to the wider framework of understanding social

reality from the point of view of the powerless through what George Lefebvre called "history from below". As Harvey Kaye has argued, the work of Maurice Dobb, Christopher Hill, Eric Hobsbawn, Sheila Rowbotham and Edward Thompson has forced a reconsideration of the question of social class in general and forms of struggle in particular:

We are now asked to see class in terms of people's experiences and activities structured especially but not exclusively by their productive relations with those experiences and activities expressed in class sometimes 'fully' class-conscious ways. But to pursue such class struggle analysis we must understand the class struggle experience in its totality and its many forms of articulation (29).

Three studies, in particular, have relevance for the perspective taken in this thesis. First, the book by Stephen Humphries, Hooligans or Rebels?: An Oral History of Working Class Childhood. In the book, Humphries traces the history of working class youth subcultures between 1889 and 1939. A central theme in this history is the resistance of working class youth to the imposition into their lives of school discipline and reformatory punishment. This resistance manifested itself in a number of different ways from subverting school syllabi, challenging the authority of teachers, organising strikes and finally to resisting the regimes in juvenile reformatories through escape attempts. Humphries' conclusions are worth quoting in full as they provide a lens through which seemingly pathological behaviour can be more clearly and correctly understood:

For young people who stubbornly resisted bourgeois institutions through sabotage at school and work, persistent truancy, violent conflicts with teachers, social crime and

street-gang subcultures were, as we have seen, major targets for disciplinary and corrective treatment in the reformatory. But this opposition could not be completely suppressed despite the constant resort to brutal authoritarian methods. The recollections of old people clearly reveal that this powerful undercurrent of resistance, which obstructed official aims even in institutions such as the reformatory, cannot be dismissed simply as an expression of the ignorance, immorality and immaturity that middle-class commentators have commonly attributed to working-class youth. Instead this resistance can best be understood as a discriminating response to the contradictions and inequality that were experienced in all spheres of life. Working-class people's memories of childhood and youth illuminate the fundamental importance of anger, resentment, and hostility in motivating the anti-social, delinquent and undisciplined behaviour of which they stand accused in the official records (30).

Frances Fox Piven and Richard Cloward make a similar point in Poor People's Movements. They see the relationship between social location, forms of defiance and resistance to domination as fundamental to poor people's social movements. They classify this resistance as structured, political behaviour which is deliberate and purposeful. It possesses a rationality and sense of direction which contradicts the functionalist accounts of Talcott Parsons and Neil Smelser who emphasise what they see as irrationality and pathology in such behaviour. As importantly, for Piven and Cloward, this rational response is focussed on specific targets within the daily experience of those involved:

.... people experience deprivation and oppression within a concrete setting, not as the end product of large and abstract processes, and it is the concrete experience that moulds their discontent into specific grievances against specific targets ... it is the daily experience of people that shapes their grievances, establishes the measure of their demands and points out the targets of their anger .... institutional roles determine the strategic opportunities for defiance, for it is typically by rebelling against

the rules and authorities associated with their everyday activities that people protest (31).

A more recent addition to this literature has been the work of Frank Mort and, in particular, his book Dangerous Sexualities. Mort analyses the relationship between power, medical knowledge and the control of sexuality from 1830 to the present. In addressing this complex inter-relationship he is concerned with avoiding the pitfalls of reductionist and functionalist schools of Marxism that have portrayed the professional expansion of doctors and psychiatrists as simply reflecting the logic of capital. Within this work there is a tendency:

to lose sight of the particular forms of power and resistance which are not directly related to the needs or interests of capital ..... what is at issue is whether a general theory of capital's needs and requirements can adequately come to grips with the internal complexities of professionalism and expertise, the production of scientific knowledge and ..... gendered power relations (32).

Additionally, he confronts the problem of agency and political struggle in this case the inter-relationship between the official networks of power and forms of resistance to medical interventions into the area of sexuality. The implementation of official programmes and policies and the resistance of individuals and groups to these policies:

are fought out through ideologies which constructed men as if they really were at the centre of the world, and many women as leaders or missionaries in the vanguard of moral reform .... Simplistic distinctions between voluntaristic notions of human agency on the one hand, and the worst excesses of

subjectless structuralism on the other, do little to help the historian. We have understood agents not only as bearers of policy and politics but also as subjects whose particular formation had effects on the campaigns they were involved in (33).

As the thesis will indicate, resistance to medical power has been integral to the development of the P.M.S. It is a history which has until now remained submerged. Close scrutiny of the development of the P.M.S. however, reveals a complex picture in which medical personnel have faced a series of different strategies from ridicule to murder in the attempt to consolidate their professional position within the prisons. In that sense, the power of the service has never been absolute but has been constrained and contested both by prisoners on the ground and by state servants such as prison officers who have remained unconvinced that medical power, particularly in its psychiatric and psychological manifestations, possesses the key to unlocking the door of criminality. Once more, resistance to medical power has found no part in the histories of prison medicine to which I referred above. Professional power has been seen to evolve benevolently and independently, uncontested in its work and unbiased in its orientation. It is the question of professional power itself and its theorisation, which is the third dimension that underpins this thesis.

#### Power and Prisons.

The question of power has long been a focus of attention both in sociology and the sociology of law (34). Within criminology, however, the marginalisation of the concept has been one of a number of theoretical weaknesses in the discipline. These theore-

tical gaps only began to be filled with the publication in 1973 of The New Criminology. While this book argued for a criminology that was both committed in practice and coherent in theory, the authors' programme for the development of a radical paradigm was not without its own weaknesses. These omissions included the schematic treatment of Marxism, the submergence of the experience of women and black people, the marginalisation of resistance and the absence of any in-depth consideration of power and the state (35). However, The New Criminology and the critical work which followed it, was important in shifting the analysis of crime and crime control away from the eclectic, individualised positivism characteristic of British criminology (36) and onto a terrain which attempted to theorise the impact that the wider dynamics of the political economy of capitalism had on individual behaviour. At the same time, the weaknesses in the theoretical base of the radical paradigm meant that concepts have been 'borrowed' and utilised from other disciplines to extend its analytical capabilities. This has led to the development of an important body of work which has included applying the insights of Nicos Poulantzas and Ralph Miliband on the state to the development of police power (37); utilising Gramsci's concept of hegemony to pinpoint the shift towards a more authoritarian state form (38); analysing the construction of black criminality from the perspective of concepts derived in the field of cultural studies (39); and critically evaluating the relationship of women to the law using the theoretical insights of feminist analysis (40). Within these studies power and the state have played an increasingly pivotal role.

A similar argument can be applied to the sociology of the prison.

It is only since the early 1970s that a critical sociological perspective has emerged to challenge the positivistic functionalism of earlier prison studies (41). These critical studies have emphasised the rationality of prisoners' behaviour particularly during major disturbances, the resistance of prisoners to prison regimes and the role of the prison in maintaining order within capitalism (42). This perspective stands in diametric opposition to the earlier studies which emphasised individual pathology and psychological degeneration within the prison population. However, as with the radical paradigm in general, there are a number of theoretical gaps in these critical accounts. As Michael Ignatieff has pointed out, there are a range of areas that remain to be addressed before a full, critical and analytical account of the prison system emerges:

We are still awaiting a new historiography of the disintegration of the nineteenth century penitentiary routines, of lock-step and silence; the rise of probation, parole and juvenile court; the ascendancy of the psychiatric and social work professions within the carceral system; the history of drug use as therapeutic and control devices; the impact of electronic and TV surveillance systems on the nineteenth century institutional inheritance; the unionization of custodial personnel; the impact of rising standards of living upon levels of institutional amenity and inmate expectation; the long-term pattern of sentencing and the changing styles of administrative and judicial discretion; the history of ethnic and race relations within the walls; the social and institutional origins of the waves of prison rioting in the 1950s and late 1960s (43).

The work of Michel Foucault in relation to the question of power provides some of the theoretical tools necessary to fill the gap relating to the ascendancy of medical and psychiatric personnel.

The Dispersal of Power.

Foucault's conception of power is based on his dissatisfaction with prevailing analyses of power relationships, especially with what he sees as the economism inherent in such analyses. Rather than reducing it to the property and possession of a dominant class, state or sovereign, power is conceived as a strategy. From this starting point, he argues that power is dispersed through the body politic of society:

power is not an institution, and not a structure; neither is it a certain strength we are endowed with; it is the name one attributes to a complex strategical situation in a particular society ... Power is not something that is acquired seized or shared ..... Power is exercised from innumerable points, in the interplay of nonegalitarian and mobile relations (44).

In this sense, then, Foucault is interested in the means through which power is exercised and the effects of this exercise. As Barry Smart has pointed out:

Foucault's methodological prescriptions steer research on power away from the juridical - political theory of sovereign power and an analysis of the state, to a consideration of the material techniques of power and domination which began to emerge in the seventeenth and eighteenth centuries. The new mechanism of power which emerged at that time was not compatible with relations of sovereignty; it was exercised over bodies through a system of surveillance and via a grid or network of material coercions which effected an efficient and controlled increase (minimum expenditure, maximum return) in the utility of the subjected body. This new type of power, disciplinary power, has been described as a 'fundamental instrument in the construction of industrial capitalism and of the type of society that is



its accompaniment' and its development and exercise as inextricably associated with the emergence of particular apparatuses of knowledge and the formation of the human sciences (45).

Smart raises a second important point in relation to this thesis concerning the relationship between power and knowledge. The prison, in Foucault's view, developed not simply as a place of punishment but also as a site for the observation of those who had been sentenced. Constant surveillance and individualised documentation were corner-stones in the prison regime where a body of knowledge would be consolidated "that would regulate the exercise of penitentiary practice" (46).

The exercise of power over, and the attainment of knowledge on, a subject population are therefore closely inter-linked. When knowledge advances it is in conjunction with parallel advances in the exercise of power. As Smart notes "for Foucault there is no disinterested knowledge; knowledge and power are mutually and inextricably interdependent" (47):

The institutions of the asylum, the hospital, the prison, and the psychiatrist's couch have constituted not only contexts within which relations of power have been formed and exercised but in addition 'laboratories' for observation and documentation, from which bodies of knowledge have accumulated about the mad, the sick, the criminal, and the 'sexual' subject .... The implication of this position is not that the human sciences in each and every respect initiate or facilitate a disciplining or a regulation of conduct but that there has been and there continues to be a relationship of mutual reinforcement between the human sciences and technologies of power effecting a normalization of anomalies and problems in the social domain (48).

Additionally, the axis of power/knowledge is underpinned by a new regime of coercion aimed specifically at the body. This is called "discipline". For Foucault, it is a type of power geared to breaking down the population into groups and fragmenting those groups into individual cellular spaces within hospitals, prisons, workshops and schools. It "breaks down activities and actions into simple, momentary movements thus allowing their control and ordering through routines and time-tables" (49). Within institutions, discipline, coercion, observation and the installation of hierarchies are inter-linked in a network of power. The examination of the individual's body and mind is related to this exercise of power (50).

Power is thus exercised from a variety of points both in and on the social body. It is relational in that:

We must escape from the limited field of juridical sovereignty and state institutions and instead base our analysis of power on the study of the techniques and tactics of domination (51).

Conceptualising power in this way leads Foucault to the idea that resistance to power is also relational. In other words, "where there is power, there is resistance" (52). He emphasises the different kinds of opposition that have emerged in Western societies, opposition which cannot simply be reduced to the notion of class struggle. These oppositions include women struggling against male power, children against parent power, the mentally ill against psychiatric power, sections of the population against medical power and struggles against administrative bureaucracies who attempt to determine the way individuals and populations live (53).

These forms of resistance share a number of common characteristics and:

stand opposed to a particular technique of power, one which pervades everyday life, categorizes individuals, marks their individuality and attaches them to their identity ..... (54).

In 1985, Stan Cohen published Visions of Social Control. This important book developed and applied Foucault's insights to trace shifts in the ideas surrounding, and responses to, crime and delinquency in North America and Western Europe. Cohen saw Foucault's conception of power as "his greatest strength" and while totally opposed to his "structuralist denial of human agency" (55) nonetheless used his concepts to focus on the organised response to crime and delinquency on the two continents. Importantly, for Cohen, such responses could "be sponsored directly by the state or by more autonomous professional agents in say, social work and psychiatry" (56). From this starting point, Cohen traced the impact of systems of classification and control, the development of therapy and the emergence of professionals as "a new army of technicians" (57). This included doctors, psychiatrists, chaplains and penologists who provided "theories which would justify punishment as an exercise in changing the mind" (58).

Like Foucault's work, Cohen's book is rich in ideas and stimulating in its sociological and intellectual content. The application of Foucauldian methodology to the particular question of classification in prisons has added a significant new dimension to the study of the internal management of penal regimes. As Cohen explains:

In prisons, the magic wand of classification has long been held out as the key to a successful system. If only those who mess up the regime could be weeded out (sent to special prisons, units or isolation centres) the system could go ahead with its business. All that has changed over the last century is the basis of the binary classification. It used to be 'moral character', sometimes it was 'treatability' or 'security risk' now it tends to be 'dangerousness' (59).

The "new army of technicians" is intimately involved in these processes. Their professional expansion and legitimacy allows them to create categories of deviance by setting the boundaries of behaviour, defining who belongs to the special populations created and:

slotting them into one or more category. The power to classify is the purest of all deposits of professionalism. This is what Orwell meant when he said that the object of power is power. And this is what Foucault meant when reminding us that power is not just a force that excludes and says 'No' but a form of creation: 'We should not be content to say that power has a need for such and such a discovery, such and such a form of knowledge, but we should add that the exercise of power itself creates and causes to emerge new objects of knowledge and accumulates new bodies of information' (60).

Visions of Social Control, therefore, adds empirical flesh to the theoretical bones of Foucault's initial argument. Both have significantly contributed to the analysis of power, particularly in its medical and psychiatric manifestations.

As I shall indicate, the processes described by Foucault and Cohen in relation to professional groups can be applied to the development and consolidation of the P.M.S. Those who have staffed the

service from the late eighteenth century to the present have built their position on their unique access to, and surveillance of, the confined. This applies to prisoners individually and as a collective social body. Such surveillance and the knowledge generated has been inextricably tied to the processes of less eligibility referred to above. Additionally it has also been tied to the narrow concern of managing the system internally and in a wider sense to contributing to the policing of more general social divisions. The creation of categories of deviance has been a central element in this process, particularly from the 1880s onwards when prison doctors such as R.F. Quinton took an active part in the debates about the philosophy of imprisonment and the wider social problem that the 'dangerous classes' appeared to pose to the health of the society. As I shall show, normalisation of the individual criminal and of the class has been a prerogative which has governed the everyday work and research of prison medical personnel. Categorisation through observation has not only contributed to the doctors' claims to be treated as professionals but ideologically has sustained the individualised views of criminality and its restricted class-based location that have come to dominate popular and academic analyses of the problem. In that sense prison medical workers through their researches have helped to create new categories of deviance and in so doing have contributed to that very narrow understanding of criminal (and more general social) behaviour which predominates in our society.

The disciplinary web which lies at the centre of penality and in which prisoners have been positioned has thus underpinned the work of prison medical workers. At the same time, it is a web which has

often proved to be fragile and brittle as prisoners and their supporters have contested the nature of the interventions made by this group into their lives. It has also proved fragile in a more general sense for even on their own terms prison medical personnel are no nearer to uncovering the roots of criminality or disorder than their 18th and 19th century counterparts. Taken together, both challenges raise fundamental questions about the efficacy of medical power in dealing with penal and social problems. It is the significance of this point rather than acquiescing to further medicalisation that contemporary prison managers might care to ponder.

## Chapter 2

### The Organisation and Role of the Contemporary

#### Prison Medical Service.

Prison doctors practice a restricted form of medicine with restricted patients in restricted circumstances which may lead to them becoming both deficient as doctors and as "institution-alised" as the prisoners they are treating (1).

Medical staff in the prison system in England and Wales are organised on a hierarchical basis. This hierarchy operates at two levels.

First, those such as hospital officers, nurses and pharmacists who provide medical care on a daily basis are responsible to the prison doctor in each prison. Second, each occupational group within the P.M.S. is itself hierarchically organised. Thus, for example, those who work as doctors follow a chain of command up through senior and principal Medical Officers to the Director of the Prison Medical Service.

The Director is head of the P.M.S. and is based within the Directorate of Prison Medical Services in Cleland House, Page Street, London (2). The Director is responsible to the Director-General of the Prison Service for medical and nursing services as well as advising the Prison Department and other divisions of the Home Office on all matters affecting the health of prisoners (3). In December 1982, Dr John Kilgour was appointed as the new Director of the P.M.S. Kilgour was a former Assistant Director of Medical Services Far East Land Forces and Chief Medical Adviser to the Ministry of Overseas Development. At the time of his appointment he was the Director of Co-ordination of the World Health Organisation and succeeded the Acting Director, Ronald Ingreys-Senn who was retiring (4). He had never worked in the P.M.S. before starting on 1st October 1983. This was the first time since the beginning of the Service over 100 years previously that "an 'outsider'[had]



become director" (5). The new Director, as is normal practice, had a seat on the 12 person Prison Board, which, according to the Home Office "formulates major policy and takes important decisions" (6).

Within the Directorate, the Director is assisted by a number of other medical personnel. This team includes a Deputy Director who is also responsible for the South West Prison Region and three principal Medical Officers representing the different prison regions of North, Midlands, and the South East. In addition, there is the head pharmacist and the head of nursing services (7). They are supported by a number of administrative staff. The principal Medical Officers are responsible for giving advice on medical aspects of delegated case-work as well as managing the medical services in their allotted prison regions. This management includes monitoring, guiding and regulating medical services in the prisons in these regions, thus acting as "a link between the Medical Directorate and the field" (8).

In "the field" the day-to-day management of medical services in individual prisons is the responsibility of the Prison Medical Officer (P.M.O.). This management takes two forms. Either, the doctor works full-time at the prison to which he/she has been designated or is a part-timer who is a general practitioner appointed by the Home Office to work in the local prison. The part-time doctors remain National Health Service employees but "are contracted to the Home Office to whom they are responsible" (9). Like their full-time colleagues, the part-timers sign the Official Secrets Act which emphasises that they are likely to be prosecuted

if they publish or verbally transmit without official permission any information which they might acquire during the course of their job. The bulk of primary medical care in prisons is in fact provided by these part-time G.P.s. In July 1986 there were 107 of these doctors in post, 10 short of the establishment figure. Sixty five of them spent less than 10 hours a week in prison and only two were women (10). In 88 of the 116 prisons in England and Wales "a G.P. acts as a 'managing medical officer' formally supervised by a full-time Senior Medical Officer at another prison but in practice left much to his own devices" (11).

In July 1986, there were 98 full-time officers in post, one short of the establishment figure. They were arranged in a hierarchical order which comprised of 8 principal M.O.s, 24 senior M.O.s and 66 ordinary M.O.s. Twelve of the 98 were women and the majority were over 50. Twenty nine had qualifications in psychiatry, 6 in obstetrics, 5 in gynaecology and around another dozen were qualified in pathology, anatomy, neurology, public health, tropical medicine and anaesthetics. According to the House of Commons Select Committee on Social Services, the UK "is the only country in the West where a body of full-time prison doctors are directly employed by the prison authority" (12).

The daily work of both part-time and full-time doctors is supported by visiting consultants individually contracted to the Home Office on a sessional basis. In July 1986 there were 250 of these visiting consultants of whom 170 were psychiatrists (13). Other consultants included genito-urinary specialists, surgeons, radiographers, orthopaedic surgeons, dermatologists and anaesthetists, while

others are called in when necessary. The Social Services Committee pointed out in its report that "some of the visiting specialists are NHS consultants, others are 'appointed specialists' - retired consultants or private practitioners. The whole system is remarkably vague" (14). Despite this vagueness prisoners frequently use the system. In the fifteen month period between 1st January 1984 and 31st March 1985, the number of prisoners referred to these visiting specialists was 121,337. Table 1 below indicates how these visits were distributed amongst the specialists.

Table 1 (15)

<u>Visiting Specialists and Consultants</u>	<u>Number of prisoners referred</u>	<u>Percentage</u>
<u>Appointed Specialists</u>		
Dental Surgeon	71,320	59
Psychiatrist	15,883	13
Optician	12,511	10
Venereologist	11,196	9
Physiotherapist	2,788	2
<u>NHS Consultants</u>		
Psychiatrist	3,290	3
Physician	2,221	2
Surgeon	2,128	2
Total	121,337	100

National Health Service facilities are also used for those women prisoners who are pregnant. In the period from January 1984 to March 1985, 71 women gave birth while in prison, in all but one of these cases, the prisoners were transferred to outside hospitals for the delivery and then returned to the prison afterwards (16).

Organisationally, there are three units in English prisons for mothers and babies which provide 74 places in total. There are 40 places for pregnant women and 34 places for mothers with babies. Table 2 below indicates the situation and distribution of these places.

Table 2 (17)

Prison	Places for Pregnant Women	Places for Mothers and Babies
Holloway	12	7 for babies up to 9 months old
Styal	22	12 for babies up to 9 months old
Askham Grange	6	15 for babies up to 18 months old
Total	40	34

The organisation of medical facilities varies between prisons. In bigger prisons there are both part-time and full-time doctors employed. In the smaller prisons only part-time doctors are at work. In those prisons with more than one doctor it is the senior doctor who is responsible for "organising this team of specialists in his own establishment and for supporting the medical services of the satellite establishments coming under his medical jurisdiction where it may be necessary for services to be shared" (18). Where there is no full-time doctor, emergency cover and day to day provision is provided by the visiting G.P. who usually visits each morning. As Richard Smith has indicated, the relationship between part-time and full-time doctors and their prisoner patients is not necessarily straight-forward for:

Even in prisons that have full time doctors much of the day to day care is provided by part time prison doctors. Brixton, which is London and the South East's remand prison and which has 77,000 new prisoners passing through its gates each year, has seven full time doctors, but the day's surgeries and the admission consultations are often done by part time doctors. At Long Lartin, a maximum security dispersal prison near Evesham, there is a full time prison doctor for the 400 or so inmates, but a local general practitioner comes in each morning. The full time doctors tend to be concentrated in the big local prisons, where there is a large turnover of prisoners and many court reports to be written, and in prisons like Grendon Underwood or Parkhurst, which contain hospitals and special facilities for disturbed prisoners (19).

The inspections conducted by the Chief Inspector of Prisons in various prisons also highlighted some of the issues surrounding the organisation of medical services in these places. At Gloucester prison which was inspected in 1981 and which had a population of 330 prisoners, the medical service was in the hands of a part-time Medical Officer who had been attending the prison for nearly 30 years. He was supported by a Hospital Principal Officer, three Hospital Officers, local NHS specialists and "other specialists" (20). By contrast in Durham, which was also inspected in 1981, the population of 800 men and 32 women was covered by a senior M.O. and three M.O.s. Night cover was provided by local G.P.s. In addition there was a Chief Pharmacist, a Hospital Chief Officer II and 20 uniformed grades. Women were kept in H Wing which was staffed by a Senior Nursing Sister and a State Enrolled Nurse with psychiatric experience. There were vacancies for two nursing sisters (21). And in October 1985, the Chief Inspector gave this account of the organisation of medical facilities at Norwich prison whose responsibility lay with:

The Senior Medical Officer who before joining the prison service had been in general practice locally. He also exercised oversight of medical facilities at Blundeston, Highpoint and Wayland Prisons, Hollesley Bay Colony, Youth Custody and Detention Centre. The M.O. who assisted him had only been in post for a few weeks at the time of our inspection. For the 18 months preceding her arrival he had had to work on his own and had been unable to visit the other establishments for which he was responsible (22).

A local general practice of five partners provided night and week-end cover for the doctor and also assisted in dealing with sick parades. The uniformed staff consisted of a Hospital Officer, four Hospital Senior Officers and sixteen Hospital Officers. The prison staff were supported by a consultant psychiatrist and a consultant forensic psychiatrist (23).

Every prison has an area designated as the hospital. This area varies enormously between prisons. In the majority of prisons the hospital is a sick bay which provides accommodation for patients in wards and/or single cells. In addition there is a place to store and dispense medicines and consulting rooms for doctors and visiting specialists. In contrast to this there are surgical units at three prisons: Parkhurst on the Isle of Wight, Walton in Liverpool and Wormwood Scrubs in London. A fourth unit at Grendon Underwood had been closed in 1982. In 1986 The House of Commons Social Services Committee indicated that:

During the time of our investigation only the Parkhurst unit - the one which takes Category A prisoners - was in operation and here according to the Head of Nursing Services operating facilities and standards are avowedly inadequate. One of the two post-operative wards was closed apparently because of staff shortages. The unit is shortly to be modernised. The busiest unit

at Liverpool has just been reopened following major refurbishment. The Wormwood Scrubs unit has been out of action since 1981 and may not re-open till 1991 (24).

The conditions in hospital wings have been the subject of critical comment from the Chief Inspector of Prisons (25), from Dr. Benjamin Lee, the former part-time medical adviser to the Prison Inspectorate (26) and finally from the National Association for the Care and Resettlement of Offenders (NACRO). In January, 1986, NACRO pointed out that many members of the Prison Medical Service themselves felt that the "gloomy corridors" of cells which served as psychiatric wings for mentally abnormal prisoners in Brixton and Liverpool "are quite unsuitable for holding [them]" (27).

Prison hospitals are in constant use. Between 1st January 1984 and 31st March 1985, a total of 50,784 prisoners were admitted to prison hospitals. Broken down by gender, 45,488 were males and 5,296 were females (28). Table 3 overleaf provides a long-term perspective on this issue by indicating the daily average number of sick treated in the decade 1970-1980.

Table 3 (29).

Daily Average Number of Sick Treated  
in Prison Hospitals 1970 - 1980.

Category	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980
Daily Average Number of Sick Treated in Prison Hospitals											
<u>Males</u>	1,176	1,158	1,136	1,114	1,104	1,122	1,081	1,029	1,000	1,111	1,050
<u>Females</u>	199	146	125	134	142	165	158	193	211	187	186
Average Daily Prison Population											
<u>Males</u>	38,040	38,673	37,348	35,747	35,823	38,601	40,161	40,212	40,409	40,762	40,784
<u>Females</u>	988	1,035	980	1,027	1,044	1,219	1,282	1,358	1,387	1,458	1,516
Daily Average Number of Sick as a Percentage of the Average Daily Prison Population											
<u>Males</u>	3.1	3	3	3.1	3.1	2.9	2.7	2.6	2.5	2.7	2.6
<u>Females</u>	20.1	14.1	12.8	13	13.6	13.5	12.3	15	15.2	12.8	12.3



As Table 3 illustrates when taken as a percentage of the daily average population women were consistently more likely to be treated as sick in prison hospitals than men. A similar question arises over the number of medical treatments dispensed each day. In 1982, for example, the number was consistently higher in women's prisons than in men's. In male prisons the average medical treatment per prisoner, per day, was 0.32; in women's prisons it was 1.22. As the Prison Department succinctly commented "the number of treatments given per person per day [female prisons] was much higher than for males" (30). This relationship between women, prison and medicine is explored more fully in Chapter 6.

Prison medical wings also have cells for the containment of refractory, violent and suicidal prisoners, the last of which require that a special watch be kept on them. These segregation cells are of three types: special cells, protected cells and stripped rooms.

Under Prison Rule 45, the governor is given the authority to place a prisoner who is violent or refractory in a special cell. Instructions for the use of these cells are contained in the Prison Standing Orders. These Orders make provision for the supervision of the prisoner by the governor, M.O. and the Prison Board of Visitors. In 1982, the Chief Inspector of Prisons in his annual report noted that the design of the special cells seemed to "vary substantially between establishments" (31) but that most of them had a double door, a degree of soundproofing, a "facility to enable staff to observe the occupant without risk and furniture which is incapable of causing injury" (32). If a special cell is used on the orders of the governor, then its use must be reported to the M.O. and the

record of the segregation must be made available to the Board of Visitors. However, as the Prison Reform Trust has indicated "he is under no obligation to inform the Board of Visitors at the time of use" (33).

The protected room is not referred to in the Prison Rules but is described in the Standing Orders as a means of containing a prisoner who is violent, destroying property or making a disturbance and who would otherwise have to be placed in a mechanical restraint. Only a Medical Officer may place a prisoner in a protected room and then only on medical grounds. Protected rooms are often referred to as padded cells or 'the pads'. The walls and floors are "usually covered with a resilient material and there are no projections or furnishings" (34). While the use of padded cells has fallen in recent years, the Prison Reform Trust points out that:

there would seem to be a disturbing correlation between the decline in the use of this strictly regulated restraint and a significant rise over the same period in the use of the special cells which require no medical authorisation (35).

Finally, stripped rooms, the other means of segregation, are also not referred to in the Prison Rules, but are referred to in the Standing Orders although as the Chief Inspector of Prisons has pointed out "no safeguards are prescribed in Standing Orders" (36). They are normally ordinary cells from which the furniture has been removed as the need arises and usually "contain a mattress on which the inmate may lie" (37). These cells are used by the M.O. or the prison governor, as an alternative to protected rooms for "detaining an inmate who is violent, destroying property etc." (38).

The Prison Reform Trust has pointed out that stripped cells are used far more than the special cells or protected rooms "but are not mentioned in the Prison Rules nor reported in the Prison Statistics" (39):

It appears that although stripped cells .... are used as an alternative to special and padded cells, they are subject to none of the safeguards governing other control or protective accommodation (40).

Prisoners who are placed in such cells are given special clothing which is supposed to be untearable and cannot, theoretically, be used to injure themselves. Special blankets may also be distributed and can be changed daily, if necessary.

The prison authorities are under no obligation to make any records available to Boards of Visitors regarding the use of stripped cells. Furthermore, while any prisoner who is held by mechanical restraints or is confined in a special or padded cell, must be observed every 15 minutes and visited by the governor and Medical Officer every 24 hours:

no such instructions apply to prisoners held in stripped cells ..... Without careful and regulated visits to those held in stripped cells it is unlikely that transfer to normal accommodation will take place within a short period of the prisoner calming down. Increasingly, the evidence points to the likely use of stripped cells as 'punishment cells': unregulated, unrecorded and unofficial (41).

Control can often lie at the heart of the use of segregation cells. While the prison doctor "has particular duties to check the welfare

of individuals in special cells" (42), the use of such cells is, according to the Chief Inspector of Prisons "primarily a matter of control in the interests of security and not for use on medical grounds" (43). Similarly, when a prisoner has to be removed from a hospital room "because his behaviour makes it necessary to hold him elsewhere on medical grounds" (44) then the prison doctor can authorise the prisoner's transfer to the stripped cell. When that procedure fails "usually because the patients's behaviour is so extreme" (45) then the doctor may authorise a transfer to a protected room.

In his report on Birmingham prison the Chief Inspector of Prisons "encountered serious confusion about the designation of the rooms" (46). He supported this point in his annual report for 1982. He found that there was some confusion in the service about the circumstances in which cells should be used and the safeguards which should be applied. The report went on to point out that:

we found considerable variation in the design and equipment of these cells and rooms. In some cases too, Regional Directors had not certified the accommodation as being fit for its purpose. In the absence of sufficiently detailed guidance about the use of accommodation we have noticed that undesirable practices have been allowed to creep in. In some establishments, for example, the inmates are placed in stripped rooms for long periods, undergoing considerable deprivation, but without proper supervision or safeguards ..... We have also frequently found that the records kept for special cells and protected rooms were not satisfactory, giving no details of the circumstances in which the cells were taken into use or the names of the staff on duty and whether or not inmates had been visited by senior staff (47).

The Chief Inspector has also described the conditions in some of these cells. When he visited Durham prison he found that the special cells were:

unfit for occupation, since the protective covering to the walls and the floor had become badly damaged and the cells were impregnated with urine resulting in an obnoxious smell (48).

When the Inspectorate visited Nottingham Prison in March 1982, they found that a protected room in the hospital had been converted into a stripped cell and was being used to segregate prisoners for disciplinary reasons. It had not been certified fit for this purpose by the Regional Director. Furthermore, the Inspectorate considered that "it was inappropriate that inmates should be placed in the hospital for disciplinary reasons" (49). In terms of medical care they were also concerned to find that prisoners were required to strip in front of their fellow prisoners and that "some prisoners were being located in the main prison without having first been seen by a Hospital Officer" (50). At Ashford Remand Centre, the Inspectorate noted their concern that the protected rooms and other rooms were being occasionally used as stripped rooms but that these rooms had not been certified in accordance with Prison Rule 23. Not only did the protected room need repairing but "we were not satisfied that the staff clearly understood the correct use of the stripped room" (51).

Finally, with regard to these segregation cells, it should be noted that their use varies by gender. According to the Prison Reform Trust, women's prisons make disproportionate use of segregation in

special cells. The Trust pointed out that in 1982, special cells were used on 259 occasions in women's prisons compared with 892 occasions in men's prisons. In the women's remand prisons which had an average population of 203 in 1982, the special cells were used 202 times. In male remand centres with an average population of 2,690 special cells were used 85 times. What this means is that:

the women prisoners in the remand centres were 31 times as likely to be subject to restraint as men in similar prisons. It is well known that the prescription of psychotropic drugs and other medication in women's prisons is far higher than for men, but here the argument is always advanced that women prisoners are more likely to be suffering from mental or other illness. It is therefore worth emphasising that the use of restraints against women prisoners was without exception on non-medical grounds (52).

#### Hospital and Nursing Officers.

In December 1985 there were over 1,000 full-time nursing staff employed by the Prison Department. Within the P.M.S. a dual structure operates with regard to the organisation of this staff. In men's prisons, nursing staff are known as Hospital Officers. There were 884 in post at the end of 1985 (53). They were divided into five ranks: Hospital Chief Officer I; Hospital Chief Officer II; Hospital Principal Officer; Hospital Senior Officer and Hospital Officer. These individuals are uniformed discipline officers who receive basic medical training at either Walton prison in Liverpool or Wormwood Scrubs in London.

Nurses are employed in women's prisons. At the end of 1985, 145 were in post (54). They are also ranked hierarchically with a

Nursing Matron in Chief at Head Office followed by Senior Principal Sister; Principal Sister; Senior Sister; State Enrolled Nurse and Nursing Auxiliary (55). Nurses tend to be concentrated at Holloway and other women's prisons with a small number being employed either in the main surgical units or in one or two male prisons. These nurses usually have an average of two professional qualifications with the majority being State Registered Nurses and State Certified Midwives. Others have qualifications in psychiatric nursing. For registered nurses there is a minimum of three years training, for the enrolled nurse it is two years. According to the Home Office, nurses, unlike male hospital officers "are not highly trained in such matters as discipline, control and security"(56). However, as Chapter 6 indicates, this distinction between discipline and medicine in women's prisons is more blurred than the Home Office acknowledges.

In male prisons, the hospital officer performs an important pivotal role. The daily contact which prisoners have with the medical service is "primarily with hospital officers not doctors" (57). Just over 11% have a nursing qualification (58).

Until 1983, training for hospital officers lasted for 13 weeks and was, according to the Home Office, "designed to equip them to undertake the basic nursing required" (59). This three month training period, most of which was undertaken by Hospital Chief Officers (with some support from prison doctors, psychiatrists, psychologists and pharmacists) compared with the two years training for a State Enrolled Nurse in the NHS and three years for a State Registered Nurse (60). The course included biology, anatomy,

physiology, bacteriology, psychology, chemistry, physics and basic nursing techniques such as ward management, the elements of medical, surgical and psychiatric disorders, emergency resuscitation and prison medical administration (61). About half of the course consisted of lectures and demonstrations while the other half was spent on practical work in prison hospitals, special hospitals, interim secure units and NHS hospitals. Assessment took the form of written, oral and practical work both during and at the end of the course. Around 90% of candidates usually passed the exams to successfully graduate as hospital officers.

Following the training review which was completed in 1983, the period of training was upgraded to 26 weeks. This upgrading followed serious criticisms which had been made about the quality and length of the initial training period. In 1979, Roy King and Rod Morgan found that only 15 out of 783 prison hospital officers held formal nursing qualifications and that staff resources did not allow even the most basic form of in-service training with respect to mentally disordered offenders. They concluded that it seemed indefensible that:

prison nursing staff, concerned with the administration of drugs and the supervision of prison hospital units, are not currently required to have the same nursing qualifications demanded of persons undertaking similar duties in an outside hospital (62).

Ronald Strank a former chief nursing officer in the P.M.S. has described what happened in practice when the hospital officer finished his training:



armed with this limited knowledge and whatever experience he picked up along the way, he will be expected to interpret signs and symptoms, plus take decisive action on his observations on his own initiative. In many cases he will be the only 'medically' trained person in the prison at night and thus responsible for making decisions which can affect the life and future of an inmate. The medical officers claim that they are available by telephone. That telephone is usually in the doctor's home outside the confines of the prison (63).

Following the 1983 review, the Home Office planned "some important changes and developments" in the hospital and nursing side of the P.M.S. (64). This included the gradual movement towards a unified structure where staff would be trained in both discipline and nursing techniques. In addition, nurses would be gradually absorbed into the hospital officer structure "and women hospital officers are now being recruited from the disciplinary side" (55). The Home Office also hoped to substantially increase the proportion of male hospital officers with nursing qualifications and improve training opportunities for unqualified hospital officers (66).

#### Pharmaceutical Services.

The dispensing of drugs in prisons is carried out by pharmacists, pharmacy technicians and hospital officers who have been "trained as 'compounders'" (67). Organisationally the Chief Pharmacist is the head of pharmaceutical services and is responsible to the Director of the P.M.S. There are 14 full-time pharmacist posts situated in the bigger prisons from Liverpool in the North West to Bristol in the South West to Wormwood Scrubs in London. In addition, there are four part-time pharmacist posts at Leicester, Leeds, Rochester and Bedford. Prison pharmacists are employed

on NHS terms, while each pharmacist is responsible for the supervision of smaller prisons in the area. Pharmacists are supported by 8 pharmacy technicians and 46 compounders which the Home Office told the House of Commons Social Services Committee are being phased out as "compounders are being encouraged to take the pharmacy technician qualification" (68).

The number of prison pharmacists the Committee was told had not risen since 1966 and that consequently there was no evening or week-end cover, that medical officers in many establishments rarely if ever see a pharmacist and that "prison doctors do not have ready access to advice from the pharmacist on new drugs or possible side effects" (69).

In July 1985, Peter Downton, the Assistant Secretary of the Institute of Professional Civil Servants, the union which represents P.M.S. staff, pointed out that not only were facilities for the mentally ill "very poor or non-existent" (70) in most prisons, and that new prisons were still being built with no hospital facilities but also:

the number of qualified nursing and other related professional staff such as pharmacists are minimal, the work being done largely by prison officers (71).

Finally, while in organisational terms the psychologists who work in the prison system, do not come under the P.M.S., it is important to note their presence. There were 85 in post in July 1986, 8 of whom were qualified as clinical psychologists. They were organised under the Directorate of Psychological Services (72). Their work, and the important historical role that psychology and psychiatry have played

in prisons is considered in greater detail in Chapter 3.

### The Role of Prison Medical Staff: The Doctor.

The formal basis of the authority of the prison doctor are the official prison rules. These rules describe and give statutory force to the wide-ranging duties which he/she is expected to undertake. These duties are defined and enshrined in the 1964 Prison Rules which have been partially amended since that date. The Prison Rules are supported by Standing Orders which are "a relatively unchanging body of management rules although they are amended in minor ways" (73). The Standing Orders themselves are supported by Circular Instructions issued by the Prison Department to the prison governors. These Instructions amend Standing Orders "and provide further detail which may eventually be absorbed into Standing Orders. Out-of-date Instructions may be superceded but are rarely formally revoked" (74). Both the Standing Orders and the Circular Instructions are classified under the Official Secrets Act. They are generally not available to the public, to prisoners, nor indeed do many members of staff see them. Altogether the prison rules are:

..... diverse in character. They range from diffuse statements of general policy objectives, to definitions of administrative structure and functions to rules designed to protect individual prisoners. The latter are few in number and mostly concern procedures for discipline and control. The Rules covering conditions and facilities generally provide staff with a wide discretion (75).

Rule 17(1) and (2) succinctly describes the role of the prison doctor.

The M.O. is to "have the care of the health, mental and physical of

the prisoners in that prison" and that "every request by a prisoner to see the medical officer shall be recorded by the officer" (76). In order to carry out these duties the doctors are instructed in the Standing Orders that they have to attend the prison daily, make their services available whenever required and "examine prisoners, convicted and unconvicted for the purpose of such reports as are called for by or on behalf of the Secretary of State and for the Courts" (77). Attendances at court hearings to give oral evidence are also part of the normal duties of the Medical Officer. In the daily management of the prison, other areas are also of concern to the M.O. With regard to food, for example, the Prison Rules indicate that the doctor "shall regularly inspect [it] both before and after it is cooked and shall report any deficiency to the governor" (78).

The governor is also instructed that "no convicted prisoner shall be allowed except as authorised by the medical officer to have any food other than that ordinarily provided" (79). In addition the M.O. decides on the fitness of every prisoner for physical exercise and can excuse a prisoner from or modify any activity on medical grounds. Similarly, he/she may excuse prisoners from work on medical grounds and conversely pass prisoners fit for work on reception into prison. Finally the M.O. can "reclassify a prisoner for another category of labour, if for any reason, mental or physical such a change seems desirable" (80). In 1978, Dr Ingrey-Senn, the then Assistant-Director General of the P.M.S. described the wide-ranging nature of the M.O.'s duties, to a Howard League Conference:

The medical officer is a member of the senior management team and is expected to advise on matters concerning: food hygiene, working conditions, suitability of candidates for employment in the Service, fitness of members of the Service, accidents to inmates and staff, for adjudication, self-injury, food refusal, petitions to the Home Secretary, letters to Members of Parliament (a popular pastime for inmates), fitness for inmates to be transferred to other establishments (81).

As Ingrey-Senn indicated one of the many roles that the M.O. performs is with regard to disciplinary matters. No award of cellular confinement can be made unless the M.O. has certified that the prisoner is in a fit state of health to be so dealt with. Circular Instruction No. 20 which was produced by the Home Office in 1977 underlined the importance of the doctors in disciplinary and adjudication procedures. The instruction emphasised that "it will continue to be the normal practice for the accused to be examined for his fitness for adjudication and punishment on the day of and preceding a hearing or resumption of a hearing" (82). Doctors can also order that a prisoner be placed under restraint when he/she "becomes violent or refractory" (83). This may be done for "medical reasons on the order of a medical officer or otherwise on the order of the governor" (84). In 1984, 47 male prisoners were restrained for medical reasons and 1,059 on other grounds. The comparable figures for female prisoners were 7 and 91 respectively (85). The means of restraint varied from the use of loose canvas jackets and protective rooms for medical reasons to the use of body belts, handcuffs, ankle straps and special cells for non-medical reasons (86).

The involvement of prison M.O.s in such disciplinary matters and activities has called into question their neutrality with regard to the health and welfare of their prisoner/patients:

How can a doctor serve two masters? In his work the Prison Medical Officer has a dual allegiance, to the State and to those individuals under his care. To my mind, this can only result in activities which largely favour the State (87).

This contradiction is explored more fully in Chapters 4 and 5.

While the general duties of the prison doctors have been defined in this way, more specific areas of their work are rarely discussed. For example, doctors are advised in the Standing Orders on how to deal with particular categories of prisoner. For a prisoner who has been charged with murder the doctor is advised that the accused be admitted to the prison hospital for special observation and that a special record is to be kept of the prisoner's physical and mental condition. After this period of observation the doctor "may at his discretion direct that the prisoner is moved to ordinary location and advise the governor on matters relating to the supervision ..... employment and association activities of the prisoner" (88). For women charged with murder of a child under the age of 12 months, the doctor also has to keep her under observation and if he/she forms the opinion that at the time of the act the prisoner's mind was disturbed as a result of the birth then "he should convey that opinion to the D.P.P. at the earliest possible moment after the prisoner's reception on remand so that the charge of infanticide may be considered" (89).

For Category A prisoners, that is those prisoners in the highest security category, doctors are reminded of the importance of security considerations when such prisoners require outside medical treatment. In 1976, the Prison Department's Circular Instructions indicated that a Category A prisoner was only to be referred to an outside hospital as an exceptional course and only when the need could not be met within the Prison Medical Service. Doctors are advised that they should first consider if the patient's needs can reasonably be provided for in the prison or by consultation with and transfer to another prison rather than by sending the prisoner to an outside hospital. Finally, to avoid the repetition of cases where prisoners have escaped with "relative ease" (90) from examination rooms because of a consultant's refusal to permit the presence of prison officers during the actual examination, the Circular Instructions warn that such rooms should be examined beforehand to assure "the containment of the prisoner when he is out of the escort's sight" (91). When in the outside hospital a minimum of two officers are to accompany a Category A prisoner throughout the time that he/she is there. Furthermore, "handcuffs will be replaced on each occasion immediately before the prisoner leaves the ward or room. Closeting chains will be carried in case of need" (92). This 1976 Circular Instruction was supplemented by another in 1981 which warned that it was a matter of continuing concern to the Prison Department that there was an increase in the number of escapes from outside hospitals and that a number of prisoners had been known to "feign illness in the hope of gaining an opportunity to escape or to make an impulsive bid to gain their freedom notwithstanding a genuine illness" (93). To combat this trend, the Instruction advised that when a prisoner

is taken to a hospital, surgery or consulting room for medical or other treatment "the Governor will decide in consultation with the Medical Officer whether restraints shall be used" (94).

The role of the prison doctor also encompasses the preparation and submission of reports on individual prisoners to different state agencies. Doctors in local prisons and remand centres, for example, provide a continuous supply of medical reports both to Magistrate and Crown Courts on those prisoners remanded on bail or in custody for medical assessment. Doctors, occasionally, also submit voluntary reports. In addition, they submit reports to Prison Department head-quarters, regional offices, the Court of Criminal Appeal and the Parole Board. Finally, they make arrangements for the treatment or "psychiatric surveillance" (95) of certain prisoners after release or when released on licence by the Parole Board.

In the period 1st January 1984 to 31st March 1985 P.M.O.s prepared a total of 10,150 reports. Table 4 below provides a breakdown of these reports.



Table 4 (96)

Reports to Court by P.M.O.s

<u>Category</u>	<u>Psychiatric</u>	<u>State of Physical Health</u>	<u>Total</u>
Numbers of reports prepared on persons remanded on bail for medical assessment	185	-	185
Numbers of reports prepared on persons remanded in custody for medical assessment	9,102	219	9,321
Numbers of reports voluntarily submitted by M.O.s in addition to those above	606	38	644
Total	9,893	257	10,150

As the table illustrates, the largest number by far were those written on prisoners remanded in custody for medical assessment. Such prisoners would ordinarily be kept in the hospital wing of the prison where a prison doctor would interview and assess them. While such prisoners might experience a different regime from prisoners on remand, they do not, as King and Morgan found in their study of Winchester Prison, necessarily experience a more flexible or rewarding one (97). King and Morgan were informed by prison staff that the regime in the prison hospital was designed so that prisoners were available to medical personnel at any time. In practice, this meant that "apart from two half-hour periods of exercise their time was spent either in hospital cells or wards when they were not actually being interviewed or undergoing treatment" (98).

There has also been controversy over the psychiatric reports themselves. One Prison Medical Officer has maintained that "it is difficult to write more than two thorough reports a day" (99).

Early criminological research in the area by West and Bearcroft (100) and by Sparks (101) found that reports prepared by Medical Officers in prisons sometimes "tended to be shorter and less detailed than those made by psychiatrists at out-patient clinics, and were sometimes limited to statements that the offender was not insane or mentally defective" (102). In the first full-scale study of medical remand procedures, Gibbens, Soothill and Pope (103) found that many magistrates believed that daily observation in custody would lead to a more thorough and reliable assessment of the prisoner concerned. However, the authors believed that while this would be:

true of psychotic or more grossly disordered offenders ..... the great majority of less obviously disturbed offenders are kept in ordinary cells until called for an interview for an hour or less, similar to that provided by a Health Service consultant (104).

They also pointed to the fact that the courts might actually prefer a remand in custody not simply because useful information might be provided from medical reports but remand itself is used as a warning to offenders:

Magistrates admit that the fact that an offender has already spent 3 weeks in custody - perhaps much longer - enables them to reduce the final sentence to a non-custodial one. In a sense, the offender has already been in prison - 3 weeks in custody under conditions only slightly different from those provided for sentenced prisoners (105).

Such critiques have continued until the present. The evidence of Dr Julian Candy on behalf of the Prison Reform Trust in its submission to the House of Commons Social Services Committee outlined what he saw as the conflict between the theoretical role of the

doctors regarding reports and the everyday reality:

What is the reality? During my spell on the Parole Board I must have read at least 2,000 medical reports on prisoners. These varied strikingly in length, content and quality. Some consisted of no more than a rubber-stamp, reading 'nothing medically relevant to consideration for parole'. At the other end of the spectrum, some PMOs wrote lengthy, partly impressionistic pieces, often containing comments going well beyond purely medical issues. On the whole, visiting psychiatrists provided more relevant and balanced reports than PMOs though that was not always so. PMOs writing discursive reports tended to be harsher in their judgement of the prisoner. Experienced members of the Board learnt to discount a fixed bias towards or against the possibility of paroling prisoners (106).

Prison doctors also have the power to recommend to the courts that Hospital Orders be made with regard to certain offenders. Until 1983 such orders were made under the 1959 Mental Health Act but on 30th September 1983 a new Mental Health Act came into force which altered some of the conditions under which such orders take place. Under the old Act, Hospital Orders were of two types. First, a Section 60 Hospital Order meant that an individual could be detained for a full year in a mental hospital and that relatives could not order the individual's discharge, but had to apply to a Mental Health Review Tribunal. Section 37 in the 1983 Act replaces Section 60 of the 1959 Act and makes it possible for the Crown Court or Magistrates Court on the evidence from two medical practitioners, to commit a convicted person to hospital or guardianship. An important difference which has been noted between the two Acts is that "the order is in effect for six months rather than a full year. Similarly the initial renewal is now for a further six months, then yearly as distinct from yearly from

the beginning" (107).

The second type of Hospital Order was under Section 65 of the 1959 Act which gave Crown Courts the power to order that the accused be subjected to special restrictions either for a specified period or without limit of time. Under the 1983 Act, Section 65 has been replaced by Section 41 which provides the Crown Court with similar powers. From the point of view of prisoners this Section invests decisions about their future not only in the hands of doctors and psychiatrists but quite squarely in the hands of the Home Secretary. For example:

The patient cannot apply to a Mental Health Review Tribunal for release, as is normally permissible in hospital and guardianship orders. Instead a submission to a Mental Health Review Tribunal can be made but all the Tribunal can do is make recommendations to the Secretary of State. Only the Secretary of State can grant patients leave of absence; permit patients to transfer to other hospitals or to guardianship from one authority to another; and order patients' discharge. The Secretary of State has the power to recall the patient or take him into custody and to return him to hospital at any time (108).

Tables 5 and 6 below provide a statistical breakdown for the decade 1970-1980 of the number of men and women detained under Hospital Orders. As the figures illustrate women prisoners, as a percentage of the average daily prison population, were more likely to be detained than men.

Table 5 (109)

Hospital Orders without Restriction Order  
under Section 60 of 1959 Mental Health Act.

Category	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980
Hospital Orders without Restriction Order under Section 60.											
<u>Men</u>	846	819	744	743	706	664	625	550	453	435	450
<u>Women</u>	113	97	81	120	55	105	112	94	82	120	109
Average daily prison population.											
<u>Men</u>	38040	38673	37348	35747	35823	38601	40161	40212	40409	40762	40784
<u>Women</u>	988	1035	980	1027	1044	1219	1282	1358	1387	1458	1516
Hospital Orders as percentage of the average daily prison population.											
<u>Men</u>	2.22	2.11	1.99	2.10	1.97	1.72	1.55	1.37	1.12	1.06	1.10
<u>Women</u>	11.40	9.37	8.26	11.68	5.26	8.61	8.73	6.92	5.91	8.23	7.19

Table 6 (110)

Hospital Orders with Restriction  
Order under Section 60/65 1959 Mental Health Act.

Category	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980
Hospital Order with Restriction Order under Section 60/65.											
<u>Men</u>	240	168	146	186	144	121	113	69	117	84	72
<u>Women</u>	11	14	6	18	17	12	21	7	5	4	29
Average daily prison population.											
<u>Men</u>	38040	38673	37348	35747	35823	38601	40161	40212	40409	40762	40784
<u>Women</u>	988	1035	980	1027	1044	1219	1282	1358	1387	1458	1516
Hospital Order as a percentage of average daily prison population.											
<u>Men</u>	0.63	0.43	0.39	0.52	0.40	0.31	0.28	0.17	0.28	0.21	0.18
<u>Women</u>	1.11	1.35	0.61	1.75	1.63	0.98	1.64	0.51	0.36	0.27	1.91

Prison doctors, if suitably qualified, can also assess whether a prisoner should be transferred from prison to a psychiatric hospital. Under the 1959 Mental Health Act this was done within Section 47. For an individual prisoner transferred in this way the position is both straight-forward and stark:

Anyone transferred to hospital in this way can be kept there compulsarily until either he is thought fit enough to return to prison, or the sentence he was serving expires. If the patient is still in hospital when his prison sentence expires, he can be further detained in hospital under Section 3 of the Act provided that the required conditions are fulfilled (111).

In the period 1st January 1984 to 31st March 1985 a total of 126 prisoners - 122 men and 4 women - were transferred under Section 47 of the 1983 Act (112). Table 7 below provides a numerical breakdown of the number of men and women removed from prison to psychiatric hospitals for the decade 1970-1980.

Table 7 (113)

Removals from Prison to  
Psychiatric Hospitals 1970-1980.

Category	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980
Numbers removed to psychiatric hospitals under Section 72 and 73.											
<u>Men</u>	101	105	98	77	56	53	47	66	56	72	99
<u>Women</u>	4	7	7	2	2	5	7	5	5	11	8
Average daily prison population.											
<u>Men</u>	38040	38673	37348	35747	35823	38601	40161	40212	40409	40762	40784
<u>Women</u>	988	1035	980	1027	1044	1219	1282	1358	1387	1458	1516
Numbers removed to psychiatric hospitals as a percentage of the average daily prison population.											
<u>Men</u>	0.27	0.27	0.26	0.22	0.16	0.14	0.12	0.16	0.14	0.18	0.24
<u>Women</u>	0.40	0.68	0.71	0.19	0.19	0.41	0.55	0.37	0.36	0.75	0.53



The psychiatric component in the work of prison doctors has been criticised from a number of sources. The Royal College of Psychiatrists, for example, in their evidence to the May Committee of Inquiry into the prison system which reported in 1979, pointed out that while psychiatric hospitals and units in the NHS are inspected and posts are approved by the Royal College itself along with the Joint Committee for Higher Psychiatric Training and the Health Advisory Service, "psychiatric services in prisons are not subjected to the same degree of scrutiny" (114). The Royal College argued that the Prison Medical Officer had not been able to broaden his role and thereby reflect the changing attitudes and practices of psychiatry but "continues to have limited and restricted function" (115). Finally its evidence pointed to the:

Ethical problems which are raised by the demands of non-medical staff but the isolated medical officer tends to meet these by denying that there is a conflict. Prisoners have a right to treatment which can be denied them because of the deficiencies in the services available and because they are not free to seek an alternative (116).

In May 1982, the East Midlands branch of the National Association of Probation Officers adopted a report prepared by a working party of its members. Among the issues it highlighted with regard to medicine in prison were the problems associated with the Mental Health Act. In particular, the report pointed out that the decision to transfer mentally ill prisoners was an executive decision taken by prison staff, the NHS or specialist hospital staff and officials at the Home Office. This was a "process independent of the judiciary; there is no right of appeal, no right of representation. There is much that is objectionable to the whole procedure" (117).

In commenting on the report David Kemp pointed to the fact that:

the overwhelming majority of transfers carry the Section 74 restriction conditions. This has the effect of prolonging a prisoner's sentence to his latest Date of Release thereby at a stroke increasing his sentence by a third. His release before that date can only be with the Home Secretary's consent and although when his latest Date of Release is reached the restrictions cease he is still liable to be forcibly detained by the hospital authorities for up to another 12 months (118).

Finally, for those life sentence prisoners who become eligible for parole, the prison doctor has a role in the determination of the eventual date and timing of their release. Under Section 61 (1) of the Criminal Justice Act 1967 the Lord Chief Justice and the trial judge, if available, have to be consulted before a prisoner becomes a parolee. As an addition to this procedure, the Directorate of the Prison Medical Service will also be consulted as well as members of staff in the holding prisons who will include the prison doctor. These staff members will provide appraisals, reports and recommendations which will be included in the parole dossier of the prisoner.

Prison Medical Officers though comparatively small in number, have a pervasive influence in penal institutions in England and Wales and on the lives of those imprisoned within them. Their role extends beyond providing care for the physically ill into areas of psychiatric assessment and the day-to-day running and management of the prisons. The practice of medicine by prison doctors is therefore a complex issue, with long historical antecedents. These are explored more fully in subsequent chapters. For the moment, as was indicated above, it is important to note that the doctors are not

the only people employed and working in the P.M.S. Hospital officers, nurses and pharmacists also play an important role in the daily management of medical services inside. It is to a brief consideration of their role to which I now turn.

### The Role of Hospital Officers, Nurses and Pharmacists.

As was indicated above, Prison Medical Officers are supported in their daily duties by prison hospital officers, nurses and pharmacists. These officers play a central role in the management and administration of prison medical services. Home Office publicity booklets describe the role of the hospital officer in the following terms:

As a hospital officer you would work on wards observing, caring for and treating patients, you would assist the prison doctor on his regular tours of the ward and carry out the prescribed treatments ordered for the patients. You would also assist visiting practitioners, including psychiatrists, dentists, opticians etc. Occasional escort duties such as taking patients from one prison to another, or to an outside N.H.S. hospital, are also part of the job. On rare occasions your services may be required to escort sick inmates who are being deported. Apart from these duties, you also have an administrative role in the hospital. Report writing on patients' condition is sometimes necessary as is looking after the patients' medical documentation, hospital admissions and discharges. Hospital security and control are also essential aspects of the job (119).

The publicity brochure also informs potential hospital officers that they would need to be aware of the principles of medical confidentiality and disclosure, and that they would also need to know

"departmental and local management instructions concerning hospital management and clinical practices and procedures" (120).

The Prison Department Standing Orders, Rule 31, outlines the duties of the hospital officer. The Orders indicate that the hospital officer in charge is responsible for the maintenance of proper order in the prison hospital and for ensuring that the instructions of the Governor and Medical Officer are obeyed. The officer is instructed to take care that all parts of the hospital and all beds, bedding, clothing and appliances are kept clean and in good condition. Furthermore, in frequently visiting the hospital rooms and wards, the officer is to ensure that "prisoners are served with their proper diets, medicines and medical comforts and that the treatment ordered by the Medical Officer is given" (121). Hospital officers are also expected to assist the Medical Officer "as the latter may require" (122), prepare diet sheets, assist in keeping the hospital case papers, diet cards and register and to perform any other clerical work that is required to keep the hospital records up to date. They are further instructed to superintend the disinfection of hospital beds and prisoners' clothing as well as being required to sleep in the hospital at night if requested to do so by the doctor. Finally, they are expected to visit any prisoner in a "serious condition and give immediate attention in any emergency" (123).

Apart from these general duties, hospital officers perform specific duties with regard to prisoners who are kept under special instructions. For example, it is the duty of the hospital chief officer or the officer in charge of the hospital

to ensure that any special instructions given by the Medical Officer, including any special instructions regarding supervision, are copied into the hospital occurrence book. Furthermore, if a prisoner is received into the prison hospital and is placed on special watch then it is the hospital officer's duty "to keep the prisoner either under continuous supervision or in his sight as far as is possible" (124). This means that if a prisoner is under special watch in a hospital cell, then theoretically he/she should be checked every 15 minutes. Hospital officers should also check those prisoners held under restraint in the hospital wing. Again, in theory, this should also be carried out every 15 minutes.

These instructions apply with equal force to nursing sisters who work in women's prisons and in the surgical unit at Wormwood Scrubs. As was indicated above, those employed as nursing sisters have had much longer training than hospital officers. To join as a sister the individual "must be a State Registered General Nurse or a Registered Mental Nurse" (125). The role that she will perform is outlined in the information sheets produced by the Home Office for prospective candidates:

The Prison Nursing Service offers you nursing with a difference - much more scope than in ordinary hospitals. Sick inmates, like any other patients, will of course demand your full care and attention. But in addition you can use your trained intuition and disciplined sympathy to help patients to cope with their difficult personalities and occasional mental abnormalities. Backed by you they can learn to face their responsibilities and problems. You can do a tremendous amount to set them back on the road to a normal, useful and happy life (126).

Prison hospital officers and nurses are therefore an integral part

of the Prison Medical Service. In certain respects, they are even more central to the on-going management and functioning of the Service than the Medical Officers themselves. For example, it is they who are continually on duty and who staff the hospitals around the clock. However, like the doctor, the role of the hospital officer in particular, has been the subject of controversy. This controversy has revolved around a number of issues:- the level of training that hospital officers receive; their isolation from medical services outside of the prison system; their involvement in isolating and disciplining recalcitrant prisoners and finally their role in the distribution of drugs to prisoners. This controversy is examined in greater detail in Chapters 4 and 5.

#### The Role of the Pharmacist.

The prison pharmacist is responsible to the governor and the Medical Officer for the provision, nature and quality of drugs used in the prison system. In addition, he/she is also responsible for ensuring the supply of dressings, pharmaceutical sundries and surgical instruments and to "ensure that they are properly stored" as well as promoting "economy in the use of medical supplies" (127). With regard to the dispensing of drugs, the Standing Orders are quite explicit about the pharmacist's role:

He will make preparations to be used in dispensing and prepare other products for medical or surgical use. He will dispense prescriptions. He will keep records as required by the Department and the various statutory regulations. He will regularly inspect all cupboards where drugs are stored in the establishment at the intervals prescribed by the Poisons Regulations. He will supervise the

pharmaceutical services at other establishments as required (128).

As indicated above, many prisons do not have a pharmacist based within the establishment. In cases like these, some of the duties of the pharmacist are undertaken "as far as possible" (129) by a hospital officer compounder under the direction of the Medical Officer. In the absence of such a compounder, medicines are obtained either from the nearest prison which has a pharmacist or by local contract.

Chief Pharmacists visit prisons at least twice a year. During the visits they inspect the stocks of medicine and drugs to ensure that they are properly labelled and stored under appropriate conditions. A Home Office Circular Instruction, distributed in 1982, indicated that Chief Pharmacists should report to the Head Pharmacist in the Medical Inspectorate about arrangements at each prison for the "purchase, supply and distribution of medicines and pharmaceutical supplies generally and ensure that all systems in force are the most professional and economic that can be achieved to meet the requirements of the establishment" (130).

Prison medical personnel are thus organised along similar hierarchical lines as other state servants in the prison system. Whilst there are formal rules and regulations listed which theoretically govern the duties and activities of medical workers, they, like their fellow prison workers, operate within a system which allows them the maximum discretion and flexibility when it comes to the practice of medicine in individual penal establishments. This discretion, underpinned both by the notion of medical professionalism

and the wider demands of the prison system, has important and far-reaching consequences for the lives of the imprisoned. It is this practice and these consequences which is the concern of the next four chapters.



### Chapter 3

#### Reconstructing the Mind, Disciplining the Body:

#### Medical Power and the Criminal 1945-1964.

During the following week a doctor at Strangeways took a look at him, 'formed certain opinions about him', and asked for a fortnight in which to make further observations. This was granted, and Harry had his first taste of psychiatric investigation.

He asked me how many times did I like to go with a woman. I said, "As many times as I can."

"How many times do you go in a night?"

"What's that got to do with you?"

"I'm trying to judge your character."

"Well," I said, "you can't judge my character by asking me how many times I go with a woman. How many times do you go with your wife?"

This was outside the scope of the inquiry, which was switched to a different but adjacent track.

He asked me how often I played with myself. "It depends where I am," I said. "If I'm in the nick I play with myself a lot, because I can't go with all these women you keep talking about. And anyway, I can't see what all this has to do with my case."

"It's got to go to court, for a Borstal report."

"What's sex got to do with Borstal?" I said.

"Do you think I'm a sex maniac or something?" (1).

..... although the criminal has been psychia-  
trized in the name of medical jurisprudence, the  
prison has withstood psychiatrization. The promise  
of forensic psychiatry, the humanitarian urges of  
liberal reformers, the triumph of medicine over  
religion - all were insufficient to establish psy-  
chiatry as the dominant power within the prison.  
The penal site that forensic psychiatry sought to  
conquer was always-already occupied by a phalanx of  
competing discourses too powerful to dislodge. The  
triumph of penalty is that by continual discursive  
realignments, the meanings of criminality and the  
aims of imprisonment forever reside in a definitional  
void. Into this void forensic psychiatry has itself  
been drawn. In return for prestige and limited powers,  
psychiatry has been assimilated by modern penalty  
and medical jurisprudence, and, within the prisons,  
it has been refashioned as one more weapon in the  
prison's never-ending quest for ideological justifi-  
cation of its power to punish (2).

..... penalty is constructed around an eclectic  
series of disparate and contradictory forms and  
logics which may sometimes be strategically related  
but are never singular or uniform (3).

In the previous chapter I discussed the organisation, role and anatomy of the Prison Medical Service in England and Wales. In detailing this anatomy I also pinpointed the rules and regulations that operate behind the prison walls which theoretically govern the behaviour of the medical jailers and the incarcerated infirm who have been put in their charge.

This empirical detail, what might be termed the 'facts' of prison medicine, is important. It is particularly apposite in the context of English prisons where information about all aspects of life inside is strictly controlled by the managers of the system. Consequently, discussion about, and debate over, the philosophy and practice of penology is heavily circumscribed by the desire, indeed the demand, to maintain secrecy (4). In providing the detailed account of the organization of the P.M.S. in the previous chapter I was concerned to follow Thomas Mathiesen's call for what he termed "action research" (5) in which academic work challenges such information control and the definitions of the normal and the deviant that necessarily flow from it. In that sense the gathering of empirical detail denies legitimacy to the power/knowledge/secrecy axis around which the majority of state institutions in the United Kingdom are organized (6).

Empirical detail about a state, or any other institution, can, however, only take an analysis so far. These data while generating knowledge about institutions only enable us to describe how particular processes work in theory and in practice they do not explain why medicine takes the form that it does in prison. In order to address this question it is necessary to move beyond the facts and basic data of prison

medicine to a position that introduces a number of the other, more sociological, dimensions which I discussed in Chapter 1.

Within critical social theory there is a long tradition that has been built around a critique of traditional social science's passive acceptance of facts as a method for understanding the world. The work of Max Horkheimer and Jurgen Habermas has been important in pointing out that "facts are not 'natural' but are shaped by human activity" (7). In Britain, Barry Smart has pursued a similar argument pointing out that in order to provide a sociological account of an institution it is necessary to recognize that "the manner and form in which 'data' 'things' or social relationships present themselves is not an adequate foundation for sociological conceptualisation" (8). Following Marx, he contends that:

Sociology attempts to achieve a scientific analysis of social life; to begin to do so successfully it must recognize the historical, socially constructed and interpreted character of social facts. The issue will become clearer when we understand that the phenomenal form in which reality appears is a product and consequence of the nature of underlying social relationships and that our sociological analysis must therefore commence by suspending belief in, by doubting, bracketing and critically examining the given 'facts', social order or society. In such terms sociology becomes a form of social criticism, a form of ideology critique (9).

This chapter will therefore build on the foundations that the critical anatomy provided by utilising other sociological tools to strengthen and deepen the analysis. Constructing an edifice from this anatomical base will involve introducing the sociological dimensions pointed to in Chapter 1. In particular, I wish to

explore the historical development of prison medicine in the crucial years between 1945 and 1964. This period encompassed the establishment of the National Health Service in 1948, a development which left the P.M.S. independent, autonomous and under the control of the Home Office. The period saw the consolidation and extension of medical and psychiatric discourses in relation to the criminal. The chapter will trace the relationship between the power of these discourses and the increasingly interventionist post-war English state. It is an analysis which assesses the impact of the power/knowledge/discipline axis identified by Foucault on the policies and practices of prison medical personnel. Finally, as I also indicated in Chapter 1, these processes were not without their own contradictions. There was resistance both from prisoners and their supporters, a resistance which denied the establishment of a full-blown medical hegemony. The parameters of that resistance have been, until now, neglected but they form a central theoretical and political part of the story of prison medicine in this period.

#### Criminality, Professionalism and Criminological Reconstruction in Post-War Britain.

The power of medicine in the post-war prison system derived its legitimacy from the reconstructionist ideology that dominated political debate in the period. That ideology rested on the belief that the state, through its employees and other professionals, should increasingly intervene into the society and more crucially, in terms of the present study, into the lives of the deviant and the criminal.

The medical profession, overwhelmingly white and male, was a powerful and well-organized voice in the debates about crime and penal policy. Prison doctors and psychologists were an integral part of the medical lobby, who despite being frequently criticised by their colleagues, were united with that lobby in terms of the explanations of criminality that were propagated. They also had one significant advantage over their colleagues. They had access to the bodies and minds of the confined to probe, test and hypothesise about criminality. In that sense, then, prison medical personnel and the medical profession in general explained criminality within well-defined theoretical parameters, which complemented and reinforced those held by other state servants, most notably the Prison Commissioners. Prisons, through the research of the doctors (and criminologists) were important sites for accumulating knowledge. It was a knowledge which reinforced the dominant views about the nature of criminality. There was, therefore, a common bond between the medical profession and the interventionist state with regard to explaining criminal behaviour and implementing policy to deal with such behaviour.

This hegemony, was, however, not complete. There were contradictions within medical theory and practice. Challenges also emerged which restricted, limited and often simply poked fun at the prison doctors and psychologists inside, as well as seriously questioning the role of the doctors from outside the prison walls. Neither however, was medicine neutral, a set of free-floating practices and policy decisions developed by individuals bereft of ideology, values and beliefs. Prison medical personnel had a particular relationship to the post-war British state, both as employees and as individuals

whose professionalism was tied to the state by the rope of reconstructionist ideology.

Additionally, the story of the Prison Medical Service after the war is one which unfolds against a background of significant development within the penal system in general. Those developments themselves are part of a larger story in which the questions of crime, deviance and delinquency and the responses to them played a central role in discussion and debates about the nature of the social reconstruction that was taking place. This reconstruction crystallised around the election of the new Labour government on 26th July 1945 which on paper was committed to satisfying the social needs of the poor and the powerless via the creation of the Welfare State.

As a number of writers have commented, the new Labour government was neither radical in its philosophy nor revolutionary in its practice (10). Rather ministers worked at "finding a solution to the class struggle within the framework of a mixed economy in which private capital set the pace, and of the parliamentary structure of the capitalist state" (11). The establishment of the Welfare State was important in ameliorating the excesses of the free market economy, offering as Kenneth Morgan has shown "an essential basis for future social advance" (12). From the point of view of the present study, what is important is how medicine came to be not only understood in the context of this social reconstructionism but positively endorsed, particularly in its more forensic manifestations, as the key to unlocking the door behind which lay the holy grail of criminological endeavour, the cause of crime.

The development of the Welfare State, the ideology that underpinned it and the policies that flowed from it provided the perfect seed-bed that allowed medical autonomy to flower and interventions to bloom.

The medical profession was in a strong position in the post-war period. The establishment of the National Health Service was not an outright victory for Aneurin Bevan, the Minister of Health in the Atlee government. From his appointment in July 1945 to the summer of 1948, Bevan fought a long-running battle with the British Medical Association and doctors throughout the country who were opposed to the idea of the NHS. The dispute revolved around three main issues. First, the doctors wanted to prevent both local and central government from intervening and "exercising any control over their medical practice." Second, they were concerned with their own economic security which they thought the state "should provide without obliging them to become salaried state employees" (13). Finally, the consultants demanded the retention of their business in the private sector. As Lesley Doyal and Imogen Pennell point out:

The British state took over responsibility for the organisation of medical care in the same way that it took over the mines, the railways or the steel industry - it was seen as a necessary part of the infrastructure for industrial production. Few additional resources were invested in medical care and power remained firmly in the hands of those who had always been in control - the doctors and administrators (14).

The hostility to the establishment of the NHS was not confined simply to the consultants. While the Socialist Medical Association argued for a health service that would be firmly based in the community and



for ending privilege in the private medical service, the majority of doctors were against its establishment. The British Medical Association published a plebiscite in February 1948, which showed that only 4,735 out of 45,549 doctors who voted, wanted the NHS (15). For Morgan, the compromise that was reached in the establishment of the NHS "went too far in giving the doctors and consultants a decisive place in the administration of the service ....." (16).

In one sense, then, the development of the NHS was a crucial advance for the overall welfare of working people. However, the power of the medical profession, while challenged, was not significantly undermined. More narrowly, within the site of criminal justice, their power for setting the parameters for debates over crime and crime control increased. The reasons for this are complex and revolve around a combination of factors. First there was the medical profession's forceful ideological claim that it could root out the causes of crime. Second, the apparent rise in crime itself which the doctors and psychiatrists claimed could be halted if the profession was given its freedom to research and experiment. Third, the nature of the social democratic consensus that was forged in the post-war period. It was this consensus built on ideologies of welfarism, interventionism and professional expertise that was the bridgehead for the expansion of doctors and psychiatrists at this time.

Social democracy, as Ian Taylor has argued, was the impetus for the growth and consolidation of professional intervention into the life of the post-war criminal. As he explains:

..... social democracy has increasingly justified its own elaboration of treatment and social control in the rhetoric of the state and of 'authority'. By this I mean inter alia to point to the continued use by liberal experts from the 1950s onwards of an increasingly private knowledge to describe and legitimate their activities (17).

The theories of criminality that professionals in general and medical (usually) men, in particular propagated clustered around a number of themes and images:- the impact of the war and the question of the physical environment, the disorganization of the family, individual psychopathology and in the case of black people sexuality and miscegenation (18). These explanations were often articulated in combination by the professionals. At the same time, each in their own way justified interventions either at an individual, family or community level to deal with the problem of crime and deviance. The justification for these interventions was to become even more pronounced as crime appeared to rise steadily during most years of the post-war period. What should be done about it taxed the collective minds of both professional medical people and intellectuals of the time.

On 12th August 1947 the Inspectors of Constabulary of Police issued their annual report. The report covered events for 1946. The increase in crime, "recurrent crime waves experienced since the war," as The Times put it was the main concern of the report's authors (19). This was underpinned by the gravity of the crimes committed. The Inspectors listed a number of factors which they believed lay at the root of the increase. These included: the fact that it was difficult to be certain of the whereabouts of older criminals because of the war; the activities of a younger group because of war conditions;

the scarcity of goods which allowed them to be disposed of at high prices; the tendency of the public to keep valuables at home and the considerable amount of juvenile crime. There was, also, it was claimed, uneasiness in the police force which was manifested in the number of officers resigning before becoming entitled to their pension. In January 1948 The Times repeated its message. The prevalence of crime, the paper's special correspondent wrote, "and particularly its increase since the end of the war is causing grave concern all over the country." Once again, juvenile crime was highlighted as "one of the most disquieting features" in this increase (20).

Within this discourse, and contrary to the thrust of recent well-publicised sociological work in the area (21) young women were regarded as a particular and serious problem to be understood and dealt with by professional medical and psychiatric intervention.

In December 1946, a Joint Committee of the British Medical Association and the Magistrates' Association approved an appendix to a report that it was preparing on the subject of the unstable, adolescent girl. The Committee acknowledged that the "existence of this type of girl in the community is a serious social problem which at present is far from being satisfactorily handled" (22). Investigation and research had concluded that her behaviour was usually the result of interaction between temperament and environment "but always at the root there is some defect of character structure that is the real cause of her difficulty" (23). This defect of character was not necessarily a defect of intellect but rather what was termed a "degree of social insufficiency". From the point of view of the

psychiatrists involved, the undesirable behaviour was closely associated with the onset of puberty:

On the emotional side there is a notable deficiency, that is to say, she is lacking in feelings of love either for her parents or anybody else; she has no sense of loyalty to her home, her school or employers; she has no sense of duty or obligation to the community; she is incapable of friendship although she not infrequently goes about with a girl who is somewhat similar to herself in tastes and temperament but whom she is quite ready to throw over or to blame if her own interests demand it. She is lacking in any kind of ambition; she seldom shows a preference for any particular type of occupation, and is lazy and lacking in drive and initiative. She is impatient of any kind of discipline or control and usually becomes sulky or hostile if she is criticized or thwarted (24).

The home life of the girls was characterised in similar terms. Their mothers and fathers were seen as either mentally defective or mentally subnormal. Moral standards were regarded as low, there was no sense of social responsibility, and additionally there were no spiritual values proclaimed so that the child lacked guidance and any influence "that might help to modify her own unfavourable innate tendencies" (25). Parents were seen as quarrelsome drunkards, work-shy and dishonest, who were often separated and gave no love to the wayward child.

The full report of the Committee was published in July 1947. Its title was The Problem Girl. The direction of its deliberations was concerned with what the members termed "good time girls" aged between 13 and 17 who appeared before the courts on charges of stealing, "because they are beyond control, in moral danger or in need of care or protection." The authors argued that such girls were not only living for their own enjoyment, but were also morally and emotionally unstable as well as being guilty of sexual misbehaviour. In

short, they were "unamenable to discipline and control" and were a "serious social problem which at present is far from satisfactorily handled" (26). Once again, the war was blamed for the disruption to the lives of the young, accenuating, it was believed, any tendency to moral or emotional instability. This was coupled with a general slackening of adult moral standards, the weakening of the sense of parental responsibility and the loss in the attraction and satisfaction that family life brought. The report concluded that emphasis had to be placed on what the authors termed "social capacity" rather than intelligence with the provision for prolonged supervision in the majority of cases. It concluded:

The committee believes that when there are sufficient institutions staffed by properly trained and experienced persons and when they have had an opportunity to show what they can do after a sufficiently long period of years, it will be seen that the psychiatric approach to the problem is the right one and is successful in the great majority of cases (27).

In August 1949, the Ministry of Education published Citizens Growing Up. The pamphlet discussed the influence of the press, cinema and broadcasting on young people and the essential part that parents should play in the upbringing of children. Again there was a sense of crisis in the pamphlet which commented that in spite of all the material, social and moral improvements in previous generations "a crisis of belief and conduct had been reached that may bring civilisation down". Thus while the state could improve the material environment and schools could provide education, it was ultimately up to parents to give the "love and understanding that enabled their children to grow harmoniously ...." On that note the pamphlet felt that women were critical:

..... all but the very exceptional girl should have some domestic training. The training of parentcraft needed to be developed in many more schools than at present, and there is urgent need for experiment in this direction (28).

The publication of these pamphlets, originating from the combined efforts of different state officials, and interested professional groups, crystalised the ideas that were developing at conferences and seminars attended by criminologists, sociologists, doctors, psychologists and psychiatrists who came together to discuss, debate and make recommendations on the problem that confronted both them as professionals and the society for whom they presumed to speak. There was a cross-fertilisation of ideas at these conferences as well as in articles, books and pamphlets of the time.

On 1st October 1949, a conference was held at the Royal Institution in London. The theme was the Scientific Study of Juvenile Delinquency. The programme had been convened jointly by the Howard League for Penal Reform, the Institute for the Scientific Treatment of Delinquency, the Institute of Sociology, the National Association for Mental Health and the Royal Medico-Psychological Association. Among the participants were the criminologist Hermann Mannheim, the Honorary Secretary of the Howard League Cecily Craven, John Bowlby the Deputy Director of the Tavistock Clinic and Alec Rodger, the Honorary Secretary of the British Psychological Society (29). The Conference was attended by representatives of government departments, local authorities, the magistracy, the Church, educational bodies and voluntary and youth organisations. The participants heard various speakers discuss topics such as intelligence and educational attainment of delinquents; the use of "cerebral surgery" with adult

criminals; personality and social factors in delinquency in particular the prolonged separation of the child from "his" mother during the first five years of its life and the relationship between crime and "dysfunction within society" (30).

John Bowlby was a central character in these debates. His argument about the crucial relationship between mother and child as a preventative mechanism for juvenile delinquency has been documented elsewhere (31). So too has the importance of Bowlby's work for the World Health Organization, in providing ideological and 'scientific' legitimation for returning women to the home after a period of relative freedom during the war (32). What has been less documented is how Bowlby's work brought together under one apparently scientific, social democratic umbrella a number of professionals, including doctors, to pinpoint the roots of criminality. As Taylor points out, Bowlby was committed to the idea that doctors and psychiatrists should join together and act as "doctors to social groups" who would help "people towards achieving better personal and group relationships" (33). A flavour of his arguments can be gleaned from his article, Research into the Origin of Delinquent Behaviour, published in the British Medical Journal on 11th March 1950. The article was based on the paper that he had presented at the Royal Institution Conference discussed above. The question of the family in general, and the mother's role in family relationships were the critical factors in the causation of delinquency. The absence of a stable mother figure "alone accounts for a high proportion, perhaps half of the most intractable cases" (34). In a supporting editorial entitled Medical Aspects of Crime, the anonymous writers supported Bowlby's overall views arguing that biological

factors played a large part in criminality, and that apart from personality, intelligence also had "a share in criminal pre-disposition .... most observers are agreed that on the average criminals tend to be persons of subnormal intelligence" (35).

The following year, there was another leading article supporting Bowlby's position. Under the title of Mental Health and the Mother the authors outlined the main planks in what they described as Bowlby's "capable survey" and concluded that:

We must take action now even though our evidence is incomplete; for "it must be remembered that evidence is never complete, that knowledge of truth is always partial and that to await certainty is to await eternity". In this case, to await certainty may well be to await a spreading of our present social sickness until it is beyond all cure (36).

Bowlby was part of a larger coterie of professional individuals and interest groups, united on a narrow terrain of personal relationships and conference attendance and pulled together by a common ideological perspective on the causes of crime. Within this perspective, the themes of individual pathology and family breakdown were the driving forces. While there was variation in terms of what was given priority, and what was emphasised, this perspective proved a fertile ground for the medical profession, psychologists and psychiatrists, supported as we shall see by criminologists, to expand on and develop not only their ideas but also the interventions that they made. Lurking behind these interventions was the spectre of social breakdown itself, if crime could not be dealt with then the social order, despite the advances made by the welfare state was in danger of collapse. Medical intervention was seen as a bulwark against encroaching disaster.



In August 1950, Sir David Henderson, Professor of Psychiatry at Edinburgh University, submitted a memorandum to the Royal Commission on Capital Punishment. In his submission, Henderson discussed the problem of "how best to deal with the sick society which exists in our midst today." He was particularly concerned with what he termed "the quality of the people" and the fact that the amount of emotional unrest and instability in the population was increasing rapidly. The explanation for Henderson was straightforward:

This is due to the fact in part at least that the poorer stocks are increasing while the healthier stocks are tending to diminish and in consequence a dysgenic situation has arisen whereby the weakly and those potentially liable to mental and nervous upsets are surviving to a much greater age than was the case previously. Socially, the position is complicated by the fact that so many married women are employed in industry. The wastage turnover is high and leads to unrest, instability and irritation not only in the factory but in the home (37).

Again, in keeping with the ideology of social reconstruction, notions of punishment and retribution were dismissed by Henderson. In his view they made no contribution towards the reformation of the individual deviant. Other methods and procedures had to be tried. For Henderson, "the fundamental problem facing everyone interested in human betterment is the improvement of the quality of the race" (38). After discussing a number of cases including individuals involved in disorderly conduct, those of unsound mind, mental deficiency, psychopathic states and psychoneuroses Henderson advocated a perspective which would include considering genetic and environmental factors in criminality at the centre of which would be "well qualified medical and nursing personnel," psychiatric units, the introduction of indeterminate sentences, a special colony established under

psychiatric control for psychopaths and "a judiciary imbued with a remedial outlook and able to think in terms of illness and disease which may be entirely subjective" (39).

The idea that inferior stocks were undermining the quality of the race was also taken up in May 1951 in the annual Cavendish lecture by Dr E.W. Barnes, the Bishop of Birmingham. The Bishop's subject was "overpopulation" and was delivered before the West London Medico-Chirurgical Society. He focussed on the problem of the expansion of the world's population which had led to a situation in which:

Everywhere communities were becoming disquietingly dense. Pressures arose in many areas from intrusive immigrations leading to racial enmity. History .... held little promise for the future of racial groups that were fashioned by overcrowding. Over-population and social progress were not natural allies (40).

The Bishop was particularly concerned with the appearance of inferior stocks such as the feeble-minded and the fact that those families in whom feeble-mindedness was "most troublesome" did not have the condition removed simply by moving them into wholesome surroundings:

The defect remained and it was to be eliminated only by eliminating the stock in which it appeared. Was such elimination possible without some measure of sterilization or infanticide? What should be the policy of a civilized race anxious to improve the quality of its people? For hundreds of thousands of years the human race had had to struggle to ensure its survival, and thereby it had acquired an outlook which was difficult to set aside, even though religious sanctions were abandoned. The average man - perhaps even more, the average woman - hesitated to admit the legitimacy of any form of euthanasia. Many, perhaps most, would not permit the elimination of defective individuals, even those whose life was a tragic burden to themselves and to the community.

The result of perserving inferior stocks in popula-

tions that were becoming excessive was to saddle the community with an increasingly heavy social burden, and probably, as the defective mutations permeated the community, there would be a lowering of the general quality of our people (41).

Henderson's original comments were also discussed in the BMJ's editorial column. The anonymous authors compared and contrasted his views with D.H. Stott's recent research published by the Carnegie United Kingdom Trust under the title of Delinquency and Human Nature. While Stott discarded psychiatric categories, he concluded that delinquency was the result of a "prolonged dynamic interaction between an individual personality on the one hand and environmental circumstances on the other." He pointed to the influence of the cinema, "the gangster and the gay life film," in particular, being cited as causing delinquent behaviour. The most important cause however, was the condition of the home and "the problem of the unsatisfactory family" (42).

Two months after the publication of Henderson's memorandum, Alan Moncrieff, the Nuffield Professor of Child Health gave a speech in response to being awarded a prize by the trustees of the Dawson Williams Memorial Fund for his work in the field of child health. In a section of the speech Moncrieff was concerned to document the problem of severe breakdowns in adolescence which led to delinquency and mental misery. This breakdown he felt could be traced to the critical early years of life when any disturbance of the "profound yet delicate parent-child relationship and especially mother-child relationship may wreak such havoc with a child's mind" (43).

Within this discourse it was working class families, in general,

and working class mothers in particular who were the central cause for concern. As early as 1945, Penguin published Juvenile Delinquency and the Law, written by A.E. Jones, a magistrate's clerk. His view is worth quoting in full as it brings together a range of the post-war themes discussed above:

Parental influence in the slums is, in any case, not so good, generally speaking, as it is in rural or middle class districts. The older traditions of family discipline linger in the country and lead to a stricter upbringing of children; and the middle classes who give their offspring the freer modern atmosphere usually have enough intelligence to prevent them from getting out of hand. But it is unreasonable to expect people who are allowed to live in conditions unfit for beasts to bring up their children like angels. Many of the badly housed part of the population have no idea how to behave as parents, and they have lost the old stern unreasoning code which was a comfort and guide and took the place of intelligent method. Youngsters experience from such mothers and fathers a continually changing succession of violently expressed moods, varying from extreme affection to foul-mouthed threats, according as circumstances stimulate their emotions. The only lesson that impressionable youth can learn from this is a similar lack of self-control (44).

In the same year that Penguin published Jones' book, Professor R.J.A. Berry addressed the Royal Society of Edinburgh. His theme was the relationship between neurones and the mind. Berry illustrated his argument by comparing the size and weights of different brains. He concluded that:

When the mentally defective are compared with the normal the mean weight of the defective brains becomes smaller and smaller as more and more severe degrees of defect are studied. Within the range of the normal there is enormous variation. As a group the largest brains were shown by university teachers; the smallest averages within normal range were shown by the shiftless and thriftless, criminals and reformatory boys (45).

As Chapter 6 indicates, the discourses around women and their supposed role in the genesis of criminality had a direct impact on penal policy for female prisoners in post-war institutions. For the moment, it is important to recognize that while the environmental and biological explanations of criminality articulated by individuals such as Jones and Berry could lead to different policy interventions at the community, family or individual level, these explanations were united on an ideological terrain which saw therapeutic intervention as the key to removing the stain of deviance from the landscape of English society. That therapy propelled by professional expertise and legitimated by the philosophy of state intervention, was underpinned by medical and psychiatric explanations of human behaviour. For the confined, it was to play a central role in prison policy throughout the post-war period.

### The Contributions of Criminologists

Criminologists too, were involved in setting the therapeutic parameters within which the debates about criminality took place. They were also eager to suggest what should be pursued as a matter of policy to deal with the problem. Organic intellectuals such as Hermann Mannheim were deeply committed as Ian Taylor points out to "the defence of a specific conception of social and moral order which would in law allow various forms of state intervention into families and also into the world of business" (46). While Taylor is correct to point to this fundamental underpinning to Mannheim's theorising, he fails to consider the full impact of this thinking in terms of reinforcing the autonomy and power of the medical and

social scientific expert while simultaneously undermining and decreasing further the power of individuals and groups to influence the direction of the diagnosis. In one of his most famous texts, Criminal Justice and Social Reconstruction, first published in 1946, Mannheim was concerned both with the crisis of values which emerged in the aftermath of World War 2 and with replanning and rebuilding the criminal justice system in order to confront the problems and chaos of the post-war world. He argued that British society had to make up its mind about what should be regarded as "the most important values in a reconstructed world" while simultaneously deciding whether "these values should be protected by the means at the disposal of the criminal law or whether their protection should be left to agencies of a different character" (47). As Taylor points out, Mannheim raised questions about the nature and impact of what he termed economic crime but this was in the more general context of reforming the criminal justice system. Central to these reforms was the notion of treatment and the place of the medical expert in that treatment. Treatment was defined in the widest sense possible and was seen as being applicable to different kinds of policies. Thus, he discusses, with chilling equanimity, the place of sterilisation and castration in the English criminal justice system and outlines the development of these measures in Nazi Germany, Scandinavia and Canada. In America, their use had been supported by the decision of the U.S. Supreme Court, where one of the judges declared that it was "better for all the world, if instead of wanting to execute degenerate offsprings for crime, or let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind .... Three generations of imbeciles are enough" (48). For Mannheim, the criminologist who was interested in

the causation and prevention of crime:

looks at sterilisation and castration chiefly as measures to eliminate certain potential causes of misbehaviour, either by transforming the patient himself or by preventing the procreation of potentially delinquent children. Controversial as may be the extent to which mental defectives and certain categories of psychotics contribute to the annual budget of crime, it is beyond doubt that their offspring considerably exceed the average rate (49).

Sterilisation should, he concluded, be permitted on a voluntary basis and for a narrowly defined group of cases. Additionally, he recommended the establishment of a treatment tribunal which would help to achieve a more scientific and more uniform system of sentencing "and better coordination between criminal courts and the authorities in charge of the penal system" (50). The tribunal would advise the courts before the passing of a prison sentence and administer the whole institutional side of the penal system. Furthermore, Mannheim proposed that the scope of the indeterminate sentence should be extended while simultaneously prohibiting by law, short prison sentences and strengthening the probation service. Finally, he recommended the abolition of trial by jury except for what he termed "political crime". His rationale for this recommendation was again related to the role of the expert and the predilection of juries to return "unjustifiable verdicts" of not guilty:

The whole idea of trial by jury has become obsolete today .... The application of scientific methods is gravely handicapped in criminal courts dominated by the jury, and its place is often taken by sophistry and humbug. To make problems of modern psychiatry clear to the average juror is impossible if presentation and discussion have to take place in the strait-jacket form of jury proceedings. The same is true of questions of evidence, whether the difficulties may be of a legal or of a psychological

character. No real progress can be made in evolving a scientific system of forensic psychology, in particular that of the witness, as long as the most complicated and serious cases have to be tried before a jury. Where laymen and professional magistrate have a chance of deliberating together, doubtful points of law or psychology can be brought out, discussed, and clarified. Although the establishment of a Treatment Tribunal would provide a solution for the sentencing stage, a more scientific handling of the legal and psychological issues involved is almost equally needed for the pre-conviction stage (51).

Where Mannheim argued for a treatment tribunal, another social democratic criminologist of the period, Howard Jones, once more raised the question of family structure and child-rearing practices. Jones' Crime and the Penal System was published in 1956. In the book, he outlined various preventative measures which were seen as solutions to the crime problem. These included what he termed the "eugenic solution" which involved sterilisation and castration. He cited the views of the criminologist W.H. Sheldon whose book Varieties of Delinquent Youth had been published in 1949. Sheldon's book had detailed the views of the eugenicists. In Jones' words Sheldon put the eugenic argument:

with brutal frankness. "Prepare for drastically reduced and for selective reproduction ..... the basic change will no doubt rest on reproduction as a kind of licensed and subsidised speciality instead of a laissez-faire competition"(52).

Jones rejected such proposals both for their fatalism and because of the "lack of certain knowledge about the inherited component in such social problems as crime" (53). Instead, he pointed to the question of family environment. Citing the theories of Cyril Burt and John Bowlby, among others, he argued that their work had shown:



The decisive role which emotional experiences within the family play in creating young delinquents of the most serious and persistent sort. The prevention of emotional deprivation in early infancy is probably the most constructive single step which could at present be taken to prevent serious criminality in later years (54).

Once again, the role of the mother was central in the process. Jones discussed the network of support available to "disturbed" families:- psychiatrists and psychologists, child guidance teams, psychiatric social workers, doctors, mid-wives, health visitors and foster homes which would provide an environment that was stable and intimate to give the child "the emotional satisfactions which he needs for healthy psychological growth" (55). However, it was the mother who was to occupy the centre stage in the emotional development of, and prevention of crime in, the male child:

Steps ..... need to be taken to ensure that the very young child is not deprived of the love and attention he needs from his mother, by being physically separated from her. There is a real danger in those parts of the country where women supply a large part of the industrial labour force. In the textile areas of the North, for instance, it is traditional for married women to go to work, leaving their children with a "grannie" - either a real grandmother or a professional "minder" (56).

Other professional voices also discussed the problem on similar lines. In June 1951, the Joint Committee of the BMA and the Magistrates' Association, which had published The Unstable Adolescent Girl in 1946 published its report on the adolescent delinquent boy. The Committee once more identified a number of factors which propelled individuals towards delinquency:- the influence of criminal homes in neighbourhoods where moral standards were low; broken homes; the absence from the home of mothers who were working; the parents were of poor intelligence

or behaved extremely foolishly. Many through either ignorance or poor mentality were quite incapable of rearing their children wisely or of good housekeeping; many delinquents were below average intelligence; overeagerness; precocious maturity; little religious education; and the cinema also played their part (57). The Committee recommended a number of diverse solutions including sex education, closer contact between youth organizations and parents, the intervention of children's officers into homes where the relationship between parents and children was unsatisfactory, pre-marital guidance, increased powers to the courts, the establishment of hostels and more research. Finally, the home was to be a central site for intervention:

Discord in the home should be dealt with as early as possible and to this end the committee recommends that those people welcomed in the home, such as the doctor, nurse, health visitor etc. should be fully cognizant of the help which can be given by psychiatric clinics of the hospitals and child-guidance clinics, by probation officers or by organizations such as citizen's advice bureaux, the Council of Social Service, marriage guidance councils, family guidance councils etc. If signs of marital disharmony are apparent they should encourage individuals to seek the advice of these or similar organizations (58).

The response of the Labour government to the problem was to introduce a number of criminal justice reforms that increased both the powers of the police and the courts as well as augmenting the power of the professional groups who were maintaining their claim that their expertise would eventually triumph. Medical personnel were central to this process.

In August 1945, James Chuter Ede, the ex-Parliamentary Secretary to the Ministry of Education had been made Home Secretary. In 1948

he introduced a Criminal Justice Bill which was more authoritarian than its 1939 predecessor, developed by the Conservative Party, but which fell with the outbreak of the war. Ede's Bill included provision for the establishment of short, sharp, shock detention centres for young people, the raising of the maximum period of preventative detention from 10 to 14 years and the abandonment of proposals for community based hostels for offenders (59). Reform of police procedures was also abandoned while the death penalty remained. This lack of radicalism in criminal justice was reflected in many other areas of the government's work and legislative programme including racial discrimination, apartheid in South Africa, gerrymandering in Northern Ireland, the status of women and the abolition of fox hunting. As Kenneth Morgan points out "on these variegated texts ... the Attlee government does not emerge, on the whole, as a body of committed or instinctive radicals" (60).

The social reconstruction of the post-war Labour government thus carried within it strong notions of discipline and control. Maintaining order through disciplinary mechanisms was underpinned by the lack of radical vision in a range of areas affecting the social and political life of the population in general and black, the Irish and women in particular trapped in the straitjacket of a hierarchical society that was, despite the war, deeply divided along class, gender and increasingly racial lines.

Social reconstruction, however, also brought with it, as we have seen, the introduction of the Welfare State within which the ideology of interventionism, therapy, diagnoses and rehabilitation flourished. Professional expertise was the cornerstone of this

rehabilitative network. What linked both strands in social reconstructionist thought was the belief that crime was out of control, and that the social order itself could be threatened and drowned in its rising tide. The Reverend Sir Herbert Dunnico, a former Deputy Speaker of the House of Commons who was retiring from the bench after 33 years service in East London, summed up the feelings of the post-war generation in his farewell speech:

in the minds of most thoughtful people today there was something akin to fear when they contemplated the future. Too many boys were carrying coshes and knuckledusters, too many were indulging in daily perjury and would end up as amateur criminals with a film star or gangster as their only god. The only concern for personal integrity, honest work and straight dealing was on the decline and a generation was emerging given to petty crime and indiscipline. It is madness to shut our eyes to the fact that maintenance of national character is impossible without faith in those spiritual ideals that braced up our people in years gone by and made our country great (61).

This was the political and ideological context in the immediate post-war period within which the prison system in general and the P.M.S. in particular developed. It is to a consideration of both that I now turn.

#### Prisons in the Post-War World.

The election of the new Labour government in July 1945, did not herald a new beginning for the prison service. While the interventions of the doctors and psychiatrists into debates about criminality were accorded even greater legitimacy within the ideology of reconstruction, for the prison system itself there was

a state of on-going crisis. There were a number of dimensions to the crisis which were inter-linked.

First, there was a significant increase in the prison population with a concomitant rise in overcrowding. This increase could even be seen during the war years when in some years the average daily population increased "due largely to longer sentences being awarded" (62). In 1945 the average daily population was 12,910, in 1950 this had risen to 20,474. In 1951 there was the "highest number of prisoners since just after 1877" (63). Overcrowding was an inevitable by-product of this increase. By 1948 2,000 prisoners were sleeping three to a cell designed for one. Such overcrowding had a 'knock-on' effect on other areas of prison life. In November 1945, Chuter Ede told the Commons that because all authorised cells in Exeter prison were fully occupied, prisoners had to be placed together in hospital cells. He went on to tell MPs that "all prisons are now severely overcrowded ..... all possible steps are being taken to deal with the situation by reopening closed prisons as they can be made available and staffed and by acquiring additional premises" (64).

The views of the Home Secretary were supported by the Prison Commissioners in the annual reports that they submitted to him. In 1946 they pointed to the "steep rise" in the average daily population from 12,915 in 1944 to over 17,300 in July 1947. They commented that it was "necessary to go back to 1913 to find a population exceeding 12,000" (65). The explanation for the increase lay in the fact that a lower proportion of men were imprisoned with short sentences, that there had been a marked decrease in the number

imprisoned for non-indictable offences and a "marked increase for indictable offences" (66). It should be noted that the Commissioners were discussing male prisoners here. It was felt that for women prisoners the situation was "developing favourably" as the average daily population fell from 1700 in 1945 to 1,022 in December 1946. This decrease was "probably due to the disappearance of war-time conditions" (67). The Commissioners, were, however, concerned that certain crimes involving women, most notably brothel keeping and cruelty to, and neglect of children were rising. They were conducting research in Holloway with a view to developing preventive work outside and to "discover what remedial treatment can be given them in the normally very unsuitable conditions of prison life" (68). I shall explore this point in greater depth in Chapter 6.

In May 1948 the average daily population passed 19,400. The Commissioners were deeply perturbed and commented that "this reversion to conditions which have not been seen for some forty years is the more disturbing in that the peak has clearly not yet been reached" (69). In July, the figure reached 20,000. Such numbers had not been seen since before World War I. The annual reports contained unsigned statements by prison governors which described the seriousness of the situation, the effects on discipline, and the pressure on bathing and visiting facilities. Additionally:

overcrowded shops and exercise yards make control most difficult. Much of the daily routine must be left to chance and the good-will of the prisoners, rather than efficiency. Serious offences of assaults and also assaults on the staff appear to be increasing (70).

By May 1951, the average daily population passed 21,800. This was the highest figure recorded since 1909. Over 70% of male prisoners were serving sentences of under 6 months which according to the Commissioners "allowed no possibility of constructive training" (71). These comments applied with even greater force to women, nearly 87% of whom, under sentence from civil courts, were serving sentences of 6 months or less. Furthermore, women were more likely than men to be remanded in custody. In 1948, the figure had been 33.6 and 19.9 percent respectively. Corresponding figures for 1949 were 36.3 and 19.4 percent.

Overcrowding was not the only problem confronting the managers of the system. The maintenance of good order inside and the prevention of escapes to the outside also presented them with serious logistical and philosophical problems in the post-war period.

In Chapter 1 I argued that resistance to domination has been an important conceptual development in cultural studies and criminology. John Clarke et al's argument that there are "potential historical 'spaces' which are used and adapted to very different circumstances" in a class's tradition of struggle provides a good insight into the implications of this conceptualisation (72). Similarly, Stephen Humphries' contention that groups exhibit discriminatory responses to contradictions and inequality again emphasises the voluntary and rational side of human behaviour. This emphasis contradicts much of the thrust of criminological discourse which has been directed at uncovering the pathological biosocial characteristics that are seen to lie at the root of criminal behaviour. The lives and experiences of prisoners have

generally been placed in the latter category, where the individual is regarded as being at the mercy of some force beyond his or her control. A closer reading and analysis of the crises of security and control in the immediate post-war period once more contradicts this individualised, pathological explanation. This is not to say that individualistic theories were abandoned. On the contrary, these theories were continually articulated, often by medical personnel, in order to explain why the fragile order of the post-war prison was threatened.

Escape attempts were an important manifestation of the conflict around, and resistance to, the domination of the prison regime. What should be noted about this behaviour is that escapes from prison are not pathological in themselves. As with all social action, this behaviour depends on the context in which an escape occurs, when it happens and from whose perspective the story of the escape is told. In the post-war period, for example, those who escaped from Colditz prison during World War 2 were regarded as national heroes. The exploits of Major Pat Reid and his fellow escapees were documented in books and on film (73). For those escaping from prisons and Borstals after the war, there was no such positive labelling. Nonetheless, the extent of this behaviour made it an important element in the prison crisis at this time, as well as a persistent expression of resistance to the prison regime.

In 1946, there were 846 escapes and attempted escapes from prisons and borstals during the year. In 1949, the figure rose to its peak of 1454 and by 1951 had fallen back to the still high number of



1,330 (74). Borstals in particular, were sites where this behaviour was often most manifest. Between 1st January and 30th June 1946, 299 youths escaped from these institutions (75).

The concern for security was underpinned by the question of prison discipline and the maintenance of control. Accounts of ill-discipline in prison have usually emphasised the pathological nature of such behaviour but again, a closer and more analytical examination of this behaviour illustrates the often widespread and complex nature of this phenomenon in the post-war period. Together with the other events described above, they were to have a significant effect on the practice of prison medicine.

On 20th December 1945, George Thomas asked the Home Secretary about the disturbances that had recently occurred in Cardiff prison. Thomas was particularly interested in the punishment given to those involved. Chuter Ede replied that six youths had been punished for taking part in the disturbances and had received between 9 and 12 strokes of the birch (76).

This Parliamentary exchange illustrates the kind of information that came into the public domain regarding such disturbances. At the same time, the restricted nature of the details, helped to reinforce the idea of individual pathology lying at the root of the conflict. An individual act or small group action had occurred, the culprits were apprehended and in due course punishment was meted out. Official departmental discourse emphasised this pathological rhetoric, often underlined by the particular attributes of those involved. This individualised rhetoric was, however, often at odds with the

Prison Department's own figures for the disturbances and conflict inside.

In 1946, 8% of the prison population was punished during the year for various offences against discipline. Two years later, the Prison Commissioners tried, briefly, to explain what appeared to be a sharp rise in the number of punishments given for acts of violence inside. The increase was attributed to the increase in the prison population, overcrowding, young men serving long prison sentences, the increase in violent offenders and the shortage of trained staff (77). In 1949, more than 14 prisoners were being punished each day for offences of violence, idleness and what the Commissioners termed "other offences" (78).

Within this general context, specific outbreaks of concerted disorder occurred. In March 1948 The Lancet discussed the prison protest that had taken place at Dartmoor shortly before Christmas 1947. Altogether 105 prisoners had refused to leave the prison yard (79). The correspondent raised questions about the punishments given to those involved and in particular the punishment based on restricting the prisoners' diet. Eighteen demonstrators had each been placed on a restricted diet for 57 days. The Lancet called for a medical inquiry into the whole issue of prison diets and dietary punishment.

Such punishments did not deter or prevent other disturbances; at Durham in December 1948, at Parkhurst in July 1949 and again at Durham in February 1950 when three prison officers were injured (80). In May 1954, two prisoners at Parkhurst were given 12 and 6 strokes of the cat each after being found guilty of incitement to mutiny

the previous Easter Monday. According to The Times, the incitement took place in the prison compound and "was intended as a demonstration against a new working time-table which was introduced on Easter Monday" (81). There were also hunger strikes and attacks on prison officers; at Stafford in March 1950, at Dartmoor in October 1953 and at Wandsworth in December 1953, for which the prisoner, Eric Mason was given 6 strokes of the cat (82). At Wandsworth in May 1954 there was another confrontation between prison officers and prisoners. There had been 12 serious assaults and one case of gross violence to a prison officer during the previous year. Twenty one prison officers were hurt in the latest incident which was followed two days later by another attack on prison officers in which two were injured. The Prison Officers' Association which was meeting at its annual conference in Birmingham passed a resolution stating that it viewed with alarm the growing use of violence against prison officers. In its view this was caused by overcrowding and a shortage of staff. Officers at Wandsworth demanded that tear gas should be used to control riots (83).

The report by the Commissioners for 1949 listed the particulars for each incident and the corporal punishment meted out. During the year, 13 prisoners were ordered to be given corporal punishment, all except one for "gross personal violence" to an officer. The one exception was for "gross personal violence to the governor of Pentonville." In 4 cases, the Home Secretary refused to confirm the decision made by the Board of Visitors. In the other 9 cases, prisoners were given either the cat or the birch.

Social order, then, was fragile in the world of the post-war prison.

When trouble erupted on a collective scale, the explanations offered and the policies introduced to cope with the ensuing disorder, focussed on the characteristics of individual prisoners. It was they who were regarded as both leading the disruption and manipulating the other prisoners into following them. In January 1952 there was another disturbance at Parkhurst. The Home Office issued a statement on the situation which pointed out that while some of the 670 prisoners had been sent to Parkhurst for medical reasons - "the climate and facilities ... being specially suitable for medical cases" - nonetheless there was still some "restlessness" among the men. The restlessness was centred amongst the preventive detainees who were in association for meals and recreation. The statement concluded that "association .... gives an opportunity to a malignant spirit to flourish" (84).

The Commissioners were to press this point further in their annual report for 1952. Since the war, the prison population had continued to climb, passing the 24,000 mark, the highest figure recorded since shortly after the Commissioners took responsibility for the prisons in 1877. By the end of the year over 5,600 men in local prisons were sleeping three to a cell and others were sleeping in dormitory conditions, in larger cells, rooms and huts. Again they referred to events at Parkhurst at the beginning of the year; razor slashing incidents; fires in the concert hall, the stores and the chapel; attempts to set fire to workshops and a store. In order to combat the indiscipline there had been a review of disciplinary procedures and powers which were strengthened by new provisions in the prison rules. As a result, "there was a great improvement in the latter part of the year and the power of the bad elements who had stirred

up trouble appeared to have been checked" (85). This line of argument was repeated by prison writers of the time. Winifred Elkin's The English Penal System, published by Penguin in 1957, mingled her own thoughts with those of the Prison Commissioners:

Finally, there is the character of the prisoners themselves. A small number are deliberate trouble-makers. They egg on others, whilst they themselves remain discretely in the background. The 1952 Prison Rules gave the prison authorities new powers to deal with such men, who can now be removed from association even if no overt offence can be brought home to them. This power operates directly by isolating trouble-makers and indirectly by deterring *many men prepared to foment trouble but not at the risk of jeopardizing their own comfort and privileges* (86).

This, then, was the institutional context in which prison medicine operated in the post-war world. As I shall now illustrate both the wider debates which I discussed above and the narrower concerns around penal politics were to have a significant impact on the policies and practices of the P.M.S. during this period.

#### The Post-War Medical Service.

At the end of the war, responsibility for the organization of the Prison Medical Service lay with the Prison Commissioners, based in Kensington Mansions, Thebover Road, London. The Commissioners were responsible for the appointment of prison doctors. Medical journals such as The Lancet carried advertisements for doctors and at the same time provided information about the service and the kind of work successful candidates would pursue. On 25th August 1945, The Lancet carried an advertisement for prison doctors describing

how at the larger prisons full-time doctors were appointed, sometimes with deputy medical officers to assist them. The advert went on:

Unfurnished quarters are provided, or an allowance made in aid of rent. Posts are pensionable and promotions are made as vacancies occur. Candidates with a diploma in psychological medicine receive £50 per annum more on appointment than candidates without this qualification and are given preference provided they also have good all-round general experience. At the smaller prisons no whole-time officers are employed; local practitioners are usually appointed as part-time officers (81).

The Report by the Commissioners for 1945 carried a similar message. The anonymous writers argued that the P.M.S. offered a career of "great interest and importance." They went on to point out that the more active psychiatric treatment that had been developed in previous years had greatly added to "the interest of medicine practiced in prison":

Further research into the causes of crime whether psychological or social will have to be undertaken in the near future and this offers an opportunity to medical men with the necessary qualifications to undertake this research either independently or in conjunction with specialists in other fields (88).

The doctors, then, were responsible for the physical health of the prisoners in their charge and increasingly, as I shall indicate, with the psychological assessment of the confined. Within the prisons the doctor had what Lionel Fox called "considerable autonomous powers and responsibilities" (89). These included examining every prisoner on reception, visiting sick prisoners daily as well as seeing any prisoner who complained of illness. In addition

the doctor was responsible for hygiene, sanitation, food, work and exercise and for prisoners undergoing "certain forms of punishment or under mechanical restraint" (90). Fox listed a range of specific responsibilities including reporting to the governor any prisoner whom he/she believed could be physically or mentally injured by continued imprisonment; drawing attention to suicidal prisoners; making recommendations for the alteration of the diet or treatment of prisoners or for their separation from other prisoners; and keeping under special observation "every prisoner whose mental condition appears to require it" who could be segregated and if necessary certified under the Acts relating to lunacy or mental deficiency (91). Finally, the doctor was to examine prisoners before discharge, and was enjoined to keep a record of the death of any prisoner.

The doctors were supported in these tasks by Hospital Officers in male prisons who were recruited mainly from men with suitable nursing experience in the Navy, Army and Air Force, or who had worked as attendants in mental hospitals. In women's prisons, the doctors were supported by Nursing Sisters who were recruited from fully trained State Registered Nurses, with Assistant Nurses in the larger hospitals. There were one or more Sisters at every women's prison, and in the large hospital at Holloway "there would be 30 or more if the staff were at full strength" (92). Finally, for women prisoners, the post-war period brought with it the legal change which allowed those who were pregnant to give birth in outside hospitals. From 1949 onwards, women could take this option. The great majority in fact did and when the baby was born, both parent and child were usually returned to the prison a day or two after the birth. According to Fox:

These babies get an excellent start in life, in spite of their inauspicious nursery, for their mothers have not only had skilled pre-natal care but are given a good training in child welfare and management, and the babies are provided with a nice little outfit to go home in (93).

The role in the management of physical illness was complemented by the involvement of the doctors in psychiatric intervention, which as indicated above, was both an important general feature of post-war social reconstruction and from the point of view of the Commissioners something that was to be encouraged. In 1932 the Departmental Committee on Persistent Offenders had recommended that "a medical psychologist should be attached to one or more penal establishments to carry out psychological treatment in selected cases" (94). By 1943 a psychiatric unit at Wormwood Scrubs had been opened and during that year dealt with 66 prisoners. Amongst the methods used for dealing with these offenders was electroencephalography (ECG) as part of their psychiatric examination. Treatment, however, did not always work. When this happened the fault lay not with either the theory or the method of psychiatric discourse but rather with the offender. As the Commissioners explained:

The largest single factor in contra-indicating treatment is intellectual inferiority ..... Six cases were transferred to a mental hospital for insulin shock treatment (IST). The results, as a whole, have not been good. This is probably due to the fact that although the psychotic manifestation was of recent origin, the personality had been unsatisfactory for a number of years (95).

During 1946, the Unit continued its work. In that year an apparatus for carrying out electric shock treatment was obtained and was used "for the treatment of certain psychiatric cases. This treatment



has been combined with psychotherapy in all cases. So far the results have been satisfactory" (96). Altogether 84 cases were "investigated" by the Unit that year and this investigation was supported by the addition of a new temporary ward with 10 beds which was used "for a selected number of cases undergoing psychiatric treatment" (97).

Behind the sanguine nature of such official pronouncements lay a series of contentious issues regarding the use of insulin shock treatment (IST) and electro-convulsive therapy (ECT). IST had only been introduced into England in November 1938 by two psychiatrists William Sargent and Russell Fraser. At Maudsley Hospital they used insulin shock to induce deep comas in schizophrenic patients, the majority of whom were women. The treatment had:

emotional connotations of infantilization. After receiving her injection, the patient was put to bed to wait for the coma. For some, the worst part was waiting for the several days it initially took for the insulin level to produce a reaction, listening to the hoarse animal cries of the other comatose women, knowing they too would slobber or grunt, wet the bed, and become ugly and grotesque; and seeing afterwards in the ward each "flushed or chalky face stamped with a sort of nullity." Being revived from an insulin coma, as Mary Cecil recalls, was a peculiarly slow and humiliating rebirth: "I tried to address a nurse who looked in, and to my horror heard only unintelligible sounds. The bedtable was pushed across and my nightgown handed to me. I changed into it with clumsy movements. It took a long time. I handled the spoon like a baby; it kept going the opposite way on the plate and then missing my mouth. I wept with shame." There were other aspects of insulin therapy, however, such as the daily hot baths, the personal attention, the diet of sugar and starch, the suggested surrogate mothering; and the infantile regression that Mary Cecil found so degrading was seen by some doctors as part of the cure. William Sargent reports that one hospital unit recommended that nurses with big breasts should have charge of the treatment so that when the patient came out of the coma, "he or she was greeted on rebirth with this invitingly maternal sight" (98).

Similarly, ECT had been developed by an Italian, Ugo Cerletti who had initially experimented with it using pigs in the slaughterhouse in Rome. It was used for the first time on humans in 1938 and was introduced in England early in 1940 by two neurologists working in Bristol. As Elaine Showalter indicates, its use soon became widespread in different institutions in England especially for women who were diagnosed as schizophrenic and depressed. In these early days, before the introduction of muscle-relaxant drugs:

the spasms produced by the current were so powerful that nurses had to hold the patient down, and fractures of the spine, arm, pelvis or leg were not uncommon. At Colney Hatch, the occurrence of fractures among patients doubled in the late 1940s with the introduction of electroconvulsive treatment (99).

As late as 1960, the Prison Commissioners reported that 12 prisoners at Wormwood Scrubs were given ECT on 49 occasions while one was given aversion therapy (100).

Despite this evidence, psychiatric assessment and interventions developed rapidly in the post-war prison. The unit at Wormwood Scrubs discussed above, was paralleled by the use of a psychological unit at Holloway which among other things classified and allocated young women to their appropriate Borstal institution. This system of classification was augmented in July 1946 with the appointment of a woman psychiatric social worker.

By 1946, the Wormwood Scrubs unit had, according to the Commissioners, become overloaded. Because of this a second unit was to be brought

into use at Wakefield to deal with cases in the North of England. Dr Roper, who had been appointed to Wakefield was also involved in the vocational selection of prison officers which according to his report for the year "absorbed a good deal of time" (101). Group tests, observation and intelligence tests were used to select candidates. From these tests it emerged that inadequacy of personality was the chief reason for rejection while "candidates of very modest intelligence, as shown by the test, have been considered suitable provided their personality and upbringing are sound; this particularly applies to the country-bred" (102).

The reports of the Prison Commissioners at this time outlined in detail the importance of this psychiatric component in the work of the doctors and other medical staff. Page after page was devoted to outlining the kind of work in which they were engaged in the search for isolating the causes of crime and treating the individual offender. Prisoners were broken down and placed into particular categories for psychiatric examination. Classification and categorisation were corner-stones in this search. Ede told the House of Commons in April 1946 that he would be reluctant to accept any suggestion that certain types of offenders should be entirely excluded from "reformatory methods of treatment." On the contrary:

The importance is fully recognised of developing scientific methods of classifying prisoners with a view to giving them the types of training best suited to their needs and capacities. The value of these methods has already been proved in the case of youths committed for Borstal training, and the plans for the future development of the prison system include the use of similar methods for the classification of prisoners whose sentences are long enough to make special courses of training

possible ..... I have no direct relationship with the General Medical Council myself; but I hope the scientific study of psychology will be undertaken by universities and other persons responsible for general education (103).

Additionally, prisoners were broken down by gender, which as I shall indicate, elicited a quite different response from the doctors. The Commissioners' Report for 1949 provides a good example of not only the centrality of psychiatric work in the everyday practice of the medical profession but also the kinds of interventions that they were making.

Under the title, Special Researches and Investigations, the Commissioners listed some of the work that the doctors were engaged in including research into the clinical histories and electroencephalographic readings of 64 murderers in Brixton prison. This research concluded that a "significant correlation existed between apparently motiveless crime and electroencephalographic abnormality" (104). Similar research was being carried out in Wormwood Scrubs under John Mackwood. At Camp Hill Borstal, the medical and discipline staffs were conducting surveys of prisoners received into the institution. The boys were to be classified either into those who were psychologically abnormal or into one of 10 classificatory categories including "hysterical swindler", "shiftless", "unethical", "emotionally unstable", "submissive" and "unclassified" (105).

The British Medical Journal outlined the kind of treatment that Mackwood and his colleagues were pursuing. Once more, they made the claim for individualised forms of treatment, looking at the characteristics of the prisoners. They also highlighted other

methods which would support the psychiatric orientation. What linked both was the focus on the individual:

The psychiatric methods of treatment which have been used so far .... are by no means the only ones that may in future be considered. Recent research - for instance the electroencephalographic studies of prisoners by Stafford-Clark and Taylor - indicates that some crimes of violence, especially those in which the motive is obscure, are related to physiological dysfunctions of the brain, and may be preventable by medical measures. It is hoped that it will eventually be possible to establish a special institute of treatment and research within the frame of the prison administration and that its functions will be much wider than merely a concern with the psychodynamic aspects of crime (106).

Inadequacy and passivity were as likely as aggressiveness to have an individual classified. One governor of a corrective training prison talked of the "woefully insipid characters" in the prison population while Dr Roper the M.O. at Wakefield, wrote in the British Journal of Delinquency in July 1950 that half the population in the prison could be classified as inadequate "and this term represents fairly well their rather vague and ineffectual personality" (107). Winifred Elkin put her own interpretation on what this term meant:

These inadequate types are peculiar through life, never looking beyond their own interests, have no particular intention or aim, are so lacking in moral stamina, intelligence, that they succumb to temptation and always take the line of least resistance. They have no scheme of life, but might be able to overcome difficulties beyond their comprehension. They hope to be successful unless they are deterred by the passive as well as by the active criminal (108).

sons, pre-

urse for

Judy and Treatment

From the point of view of the new Labour government such interventions through medical classification were an important part of the drive to find the causes of crime. In February 1946 the Home Secretary indicated the importance of the medical officer with regard to psychiatric treatment. Replying to a Parliamentary question, Ede pointed out that any prisoner at any prison could receive psychiatric treatment "if the medical officer thinks it desirable" (109). Sex offenders were a particular group within the prison population at large who were "specially examined" to see if they would benefit from treatment (110). Within this category, homosexuals were a further sub-classification who had come to the attention of the psychiatrists. In March 1949 Ede told the Commons that:

Four hundred and twelve are now serving sentences for homosexual offences. Prisoners convicted of these offences who in the opinion of the medical officer may benefit by psychiatric treatment are transferred to the prisons at which there are psychiatric clinics if their sentences are long enough. During the past six months, 40 homosexual offenders have received psychiatric treatment at these centres, and of those at present under sentence, 35 additional cases have received psychiatric examination and guidance at other prisons. Arrangements have also been made, from which prisoners convicted of these offences will benefit, to extend the psychiatric service available for prisoners who may benefit from treatment but cannot be removed to the special centres. Research, partly therapeutic in character, into the psychological and endocrinological aspects of homosexuality is being conducted at two selected prisons, and homosexuals will also benefit from research which is in progress into psychopathic personalities (111).

The desire to find a 'cure' for the homosexual prisoner, and the concern that such prisoners elicited in the prison authorities was also reflected in the work of the doctors. At the annual conference of the P.M.S. in May 1953, two P.M.O.s Drs Gray and Ogden presented

a paper entitled The Management of the Homosexual in Prisons and Borstals. In the discussion following the presentation it was recognized that the management of homosexuals in penal establishments was "a matter concerning both the discipline and medical side of the Service" (112). Because of this, one doctor described the efforts that he had made during the year to interview all homosexuals who were potential cases for psychological assessment or treatment. What is interesting to note is that these cases had previously refused the opportunity for such treatment before their reception into the prison. The doctor also had no luck in his present establishment for as he pointed out "in spite of numerous interviews, so far no prisoner was found who appeared to have a genuine desire for such treatment" (113). More generally, another felt that it was extremely difficult to "treat" a homosexual who had never experienced any heterosexual desires in a purely homosexual environment such as prison. While he could point to one "patient" who was being "treated" with a combination of hormone and psychotherapeutic treatment "homosexuals with severe character defects as a rule are not treatable." There were hopes of improvement in the stable bi-sexual:

to the extent that he may be helped to cope with his abnormal sexuality, though there will probably never be a complete eradication of abnormal impulses; but with the adult prisoner, often of poor personality and with a long history of sexual perversions frequently indulged in - and many of our patients are in this category - the prospect of improvement with psychotherapy is, I think, remote (114).

In June 1954, W. Calder, a P.M.O. at one of the London prisons, presented a paper on the sexual offender to a week-end course for psychiatrists organized by the Institute for the Study and Treatment

of Delinquency. After discussing "perversions" such as incest he came to discuss the "tremendous problem of homosexuality" which the Chief Constable of Nottingham had said was "beginning to cut into the very vitals of the nation like a cancer" (115). Calder told the Conference that "perversion, particularly homosexuality is ..... a matter for doctors entirely" and concluded that the doctor's duty was amongst other things "to undertake radical curative treatment if possible" (116). For homosexuals and sex offenders, in general, the future was quite clear:

Not only does the pervert bring shame and ruin on himself, but often on his family; and he may do immeasurable harm to others. I therefore suggest that the question of priority of treatment at clinics should be very carefully weighed; I think the sexually abnormal should have priority over most psycho-neurotics and perhaps even over some psychotics. Every case the prison doctor sees should be regarded as a medical failure - in prophylaxis at least - for, as I have said, once the case becomes a legal one, a thousand and one considerations arise, which usually of necessity dwarf the psychiatric point of view. Priority even for mental hospital beds might be considered - for those men the psychiatrists think are likely to get into trouble. If these measures fail, or are not sufficiently effective, then we can turn our minds to what is euphemistically called 'detention for an indeterminate period in a non-penal institution run on hospital lines'; if, that is, despite the antagonisms which the Lunacy, and especially the Mental Deficiency Acts, have brought upon us, we still feel it our professional duty as doctors to support this further encroachment on the liberty of the subject (117).

The attitude of the doctors to the homosexual prisoner was described by Peter Wildeblood. In March 1954, Wildeblood was sentenced to 18 months imprisonment for homosexual offences. In his autobiography Against the Law, first published in 1955, Wildeblood discussed how he had been willing to undergo medical treatment. The prison governor at Winchester sent him to see the medical officer:



The Medical Officer was a hard-bitten little Scot with grey hair brushed into a schoolboyish bang. He had been a prison doctor at Brixton for many years. He asked me how I was feeling, listened to my heartbeats, told me to sit down and began firing off the usual psychiatrist's questions, writing down my replies. Since my private life was now public property, I spoke frankly of my childhood and adolescence, while he grunted occasionally and his pen raced over the paper.

"You say you know a lot of other homosexuals. Tell me, do you frequent the orgies in which they indulge?"

"Orgies?"

"Yes, I believe in Chelsea and places there are houses where male and female homosexuals congregate to carry out unnatural practices together."

"Do they? It sounds most unlikely to me."

"So I am told."

If he has been a prison doctor for so long, I thought, possibly he knows more about it than I do.

"Homosexuals do have meeting places, of course," I said, "but they are usually quite respectable."

"What sort of places?"

"Oh, public-houses mostly. There's one in almost every district of London."

"Really? Is that so? I've never heard of that."

In that case, I thought, you are singularly ill-informed.

"Have you any hobbies?"

"Yes, plenty. Gardening, going to the theatre, cooking, painting ....."

"But no sport? No golf or tennis, for instance?"

"No."

"And what," he asked, "do you do on your free evenings? Go out importuning?"

I could have hit him.

"Certainly not. I don't do that sort of thing."

In any case, I haven't got the time. I only have one free evening a week, and I usually spend that with friends."

"Other homosexuals, of course?"

And so on (118).

As Gramsci has noted, such autobiographical accounts give a reality to events, particularly when that reality either in a country or in an institution, differs from appearances. This has special relevance when it comes to the question of law and how law works through institutions:

The person who executes the 'law' (the ruling) is enrolled in a certain social class, of a certain cultural level, selected through a certain salary etc. In fact the law resides in this executer, the way in which it - the law - is executed, especially because there are no organs of control and sanction. Now only through autobiography does one see the mechanism at work in the way it actually functions which very often does not correspond at all to the written law (119).

### Extending the Psychiatric Network.

In the light of these developments, the organisation of the P.M.S. was rationalised and the number of psychiatric personnel increased. In December 1946, the Home Office announced that "a newly created post with the title Director of Prison Medical Services" was to be established (120). This post was created in order to allow the Medical Commissioner of Prisons, Dr Methven "to devote a substantial part of his time to medical questions arising in the Children's Branch and the Probation Service" (121). Thus, a large part of the day to day work within the prisons would now be done by the new Director, Dr Young. The Home Office explained the rationale behind Methven's elevation to Medical Adviser in these terms:

Many of the medical questions arising in connection with various branches of Home Office work, particularly the work of the Children Divisions, of the Probation Division, of the Criminal Division and of the Prison Commission, are of a similar character or are inter-related. For the purpose of enabling a general oversight to be kept on all these aspects of Home Office medical work, and of insuring that experience gained in any one sphere is made available to officers working in other spheres that advice .... to the Home Secretary on questions of medical policy is based on a survey of the whole field, a new post of Medical Adviser to the Home Office has been created. Dr Methven has been appointed to be the first holder of this post (122).

Young held the Director's post until the end of 1950 when he retired. He was succeeded by Harvie Snell, the principal Medical Officer at Wormwood Scrubs (123). Snell, in turn, retired in April 1963 and was succeeded by Dr I.G.W. Pickering, formerly S.M.O. at Durham. Pickering had joined the P.M.S. in August 1947 and had been one of the first students to take the advanced course at the Institute of Criminology at Cambridge. He had also been awarded a Nuffield Travelling Fellowship for Home Civil Servants to study the medical and psychiatric aspects of European penal systems (124).

These changes at the top of the P.M.S. were complemented by other developments further down the hierarchy. The passing of the Labour government's Criminal Justice Bill in 1948 brought with it a further increase in the number of psychological staff within the prison department. The Bill itself was an important moment in the post-war reconstruction of the criminal justice system. It had a long history, its origins could be traced back to 1932 when the then Liberal Home Secretary, Sir Herbert Samuel received a Departmental Committee report on a proposed Criminal Justice Bill. In 1938, the Committee's recommendations were put into a Bill by the Conservative Home Secretary, Sir Samuel Hoare but this fell with the outbreak of World War 2. In March 1946, The Times called for its resurrection and for it to be found a place in what the paper's editorial referred to as "the programme of reform and reconstruction that was now going forward"(125). From the government's point of view the passing of the Act was to represent a new beginning in the state's response to offenders, in their words a "synthesis of deterrence and reform [that] has become known as the system of training" (126). The Bill removed some of the severe penalties which could be imposed at the discretion of the

courts. This included the power to impose sentences of corporal punishment, penal servitude and hard labour. They were to be abolished. Instead prison regimes should be oriented to the constructive training of prisoners and that such training would establish in prisoners "the will to lead a good and useful life on discharge and fit them to do so" (127).

Importantly, the Bill included more powers for the courts to obtain medical reports on offenders, if they so wished. As the British Medical Journal pointed out:

It has been difficult for a court of summary jurisdiction to obtain a report unless the offender was remanded to prison; now it will be possible to remand him on bail on condition that he submits himself to medical examination .... Power is now to be given to the court when it appears from medical evidence that the offender may be susceptible to treatment for his mental condition to require him to submit to such treatment for a period not exceeding twelve months (128).

The BMJ, in fact, emphasised the need for circumspection when discussing the feasibility of psychiatric intervention. The anonymous authors of the editorial argued that psychiatric treatment might be beneficial for only a small minority of delinquents, and that the problem was "sociological rather than medical". They wanted to encourage some sense of social obligation in individuals whose impulses appeared to be entirely selfish. The solution to the problem not only lay in religious, educational and economic influences but also with "a wise and understanding administration of the law" which was to be aimed both at the protection of society and

at the reform of the criminal (129).

Despite this call for circumspection prison doctors and psychologists increased their influence and power in the determination of an offender's pathway through the criminal justice system. This applied both to the pre and post sentence stages. The 1948 Act required that the courts consider "the prison authorities' 'suitability' reports on mental and physical health" (130). Additionally, the Act introduced two new psychiatric sentences. First, a probation order with the condition of mental treatment. Second, magistrates' courts could order hospital reception orders for those offenders who fell within the orbit of the Lunacy Acts. Such changes:

meant an increased demand for pre-sentence psychiatric examinations and reports. In addition, the internal requirements of the prison system with its growing emphasis on classification, involved the medical staff in further diagnostic work (131).

To underpin these changes and assist the medical personnel involved, supporting psychiatric services were introduced including giving greater emphasis to the psychiatric training of hospital officers, the appointment of psychiatric social workers to those prisons which had psychiatric facilities and the appointment of prison psychologists. These psychologists sat on the boards which determined whether a prisoner was to be sent to an open or closed institution (132). In the remand and trial prisons, the psychologists were to work to the medical officers, assist them in the preparation of reports to the courts and to help them fulfill the "increasing demands by the courts for reports on the psychological condition of untried prisoners" (133). They were also to be available to make reports where

necessary on convicted or Borstal prisoners. The nature of their work was to include:

the ascertainment of intelligence, the application of performance tests, education attainment tests, mechanical and other aptitude tests and general attainment tests and an opinion on the personality and character of the offender. The medical officer will take these data into account when submitting his report to the Court on the mental and physical condition of the accused (134).

By October 1953, the Home Office was able to announce that Mr A. Straker, who until then had been serving in the Admiralty had been appointed chief psychologist in the Prison Commission. This was the first appointment to the post. His duties which were to be carried out under the Director of the Prison Medical Service, were to "direct and supervise ..... the work of psychologists and psychological testers in the prison service and to advise generally on psychological work within the service" (135).

Debates in the Houses of Parliament also re-affirmed the drive towards greater classification and the application of 'scientific' psychiatric and psychological techniques to the study of criminality. The call for penology to be like medical science, the careful use of statistical methods and the demand for more research were features of the Parliamentary debate on Corrective Training in December 1949. While it was argued that "there was no division of opinion between the parties" on the subject of criminal law (136), it was felt that more research was needed if the causes of crime were to be found and its prevention "heralded":

As a matter of fact, some research has been done in America exactly along lines I suggest. The most prominent names in that connection are Mr. and Mrs. Sheldon and Eleanor Glueck. They have blazed a trail, and they have shown by careful investigation of the background that they can connect the background characteristics with the sentence and the subsequent conduct of the delinquent. Until we have that here - and it is going to be a long time - and until we are prepared to apply the scientific method of research to delinquency; until we are prepared to find out how or what particular type of delinquent responds in a particular way to a particular type of sentence, it is no use pretending that either the judiciary or the Prison Commissioners are operating under any other system than hope or guesswork (137).

From reports written by the prison doctors at the time it is clear that the passing of the 1948 Act increased both their workload and their influence. The examination of prisoners for reports was a matter for particular comment. In welcoming this increased contact one of the doctors pointed out that "the mental examination of prisoners now consumes more time than any other part of my work ... .. it is gratifying to find that our advice is almost always accepted" (139).

Other doctors made similar points, as did the Commissioners themselves who contended that while the practice of prison medicine afforded "considerable opportunity for experience in physical medicine it is recognized that the greater part of its work lies in the psychiatric field" (140). This increasing influence was reflected in the attitude of the courts and other areas of the criminal justice system which provided the overarching therapeutic umbrella within which the doctors worked. In that sense, one could comment that:

The number of observation cases at 103 remains high and the number of mental reports to court rose from 40 to 71. I find that all the courts in our area, Norfolk, Suffolk and the Isle of Ely are becoming rapidly more alert to the medical and mental aspects of crime and quite rightly refer many more cases for report under Section 26 of the Criminal Justice Act 1948. The Probation Officers and Police give me the greatest help by their reports which continue to improve in their scope and discretion upon the antecedents of these men. This in turn calls for more investigation and longer and fuller reports on my part. I have, however, felt rewarded by the appreciation of these reports shown by the Courts, and by the number of occasions when my recommendations have been accepted in every detail and acted upon (141).

In August 1950 the British Medical Journal reported that the Prison Commissioners had approached the Minister of Health concerning the psychiatric treatment of offenders serving short sentences. It was felt that the treatment such prisoners received was incomplete when the offender was discharged and if it were not continued outside then any benefit that had accrued was likely to be lost. Consequently, the Minister of Health did not object to consultants treating prisoners serving short sentences with a view to continuing the treatment if it was necessary when the prisoners were discharged. Similarly, "prison medical officers who have psychiatric qualifications could assist at regional hospital board clinics. The Minister considers this proposal to be an important social service which should be developed where possible ....." (142).

Despite these extensive developments, medical and psychiatric hegemony remained incomplete. Medical personnel were challenged from a number of different sources including the prisoners themselves, prisoner support groups outside the walls and from other state servants. For one doctor, there was a "gradual unwillingness on the part of pro-



spective recruits to join [therapy] groups and some signs of strain on the part of those who were already in groups" (143). The doctor went on to describe how the prisoners:

as a whole made fun of them and called them the looney party; some of them were willing to see it through but so much difficulty was gathering that the groups were discontinued (144).

In the unit at Wormwood Scrubs there was also resistance to the methods employed particularly to ECT. Jonathan Gould reported on 68 cases with whom he had worked for two years and pointed to the tendency of 'patients' to break off treatment:

In prison .... the general attitude of the population is far less friendly to the idea of treatment: not infrequently the patient is adversely influenced by another prisoner and this, coupled with latent anxiety and hostility, far from uncommon in prison patients, crystallizes as one of fear of the treatment. Since commencing the method of electroplexy under anaesthesia, there have been no refusals to continue the course (145).

In December 1953, speakers at a Royal Society of Medicine meeting were bemoaning the fact that prisoners were refusing to participate in the techniques of psychotherapy that the doctors were attempting to introduce. W.F. Roper, the principal M.O. at Wakefield identified the attitude of the prisoners as one of the five main difficulties of psychotherapy in prison. This difficulty was:

very important. The prisoner group as a whole tends to have a low opinion of psychiatric patients particularly those who are sexual offenders, there may, therefore, be a reluctance to accept treatment in order to avoid odium (146).

Dr Peter Scott, of Maudsley Hospital, who subsequently was to be involved in the Gwynn inquiry into the P.M.S. in 1962 (which is discussed below), made a similar point arguing that "the majority of prisoners are unwilling to become patients" (147). The strain in the relationship between psychiatrists and prisoners also emerges in the writings of prisoners at the time. This strain is underpinned both by a hostility to the philosophy and methodology of psychiatric practice and a cynicism towards the ability of this practice to actually help the prisoner reform. In that sense, then, it is important to understand the dynamics of this relationship with regard to the question of the power to categorise and the resistance to the imposition of that power into the lives of the incarcerated. The autobiography of Robert Allerton, co-authored with Tony Parker, and published in 1962, gives a clear indication of the relationship between the psychiatrist and the criminal:

I've done these tests of theirs, often, all this nonsense of bricks and blocks, fitting coloured shapes of paper into squares, picking out the odd one from lists like 'Fish-and-chips, steak-and-kidney pie, staircase'. All that sort of rubbish. I always do them wrong deliberately, but of course these people know you do it and pay no attention. I don't know why, but for some reason, when I do them wrong, I still give something away because they carry on with me despite that.

You do the test, and then go into the psychiatrist's office. He tells you to sit down, and says something like: 'You know, you're really quite an intelligent chap, I can tell from your tests'. Up to there we're doing fine, because I think if he can see I'm intelligent he must be quite a shrewd sort of geezer. This is pure conceit on my part, but it goes down well all the same when they tell me I've above average. It's after that the trouble begins, when they start probing around trying to find out what makes me tick. I don't care for this, I resent it, because if I wanted to tell them about myself I would, but I'm not going to do it at their say-so. They're not my type, these smooth-talking clever doctors, and I could never be a friend of any of them. They don't know anything much anyway, but they've conned the Prison Commissioners into giving

them a job, so good luck to them. But I'm not going to forget what they're doing is only their job, it doesn't spring from any deep-seated desire to help me. All their questions are only questions, and they don't ever come up with answers, at least not to the patient. If I go to a doctor he'll say: 'That pain in your chest is only a touch of bronchitis, you'll be O.K. Stay in bed a few days, take these pills, you'll get over it.' But a psychiatrist, never. He says nothing, tells you nothing; doesn't let on whether you're sick or healthy, sane or insane, whether you might ever be different, or whether in the long run it'd be better if you went out and shot yourself right away. They ask, but they don't tell. Perhaps this is because they don't know - but in that case why probe around in me? What are they hoping to come up with in the end - a recommendation I ought to be put away somewhere in a worse nick than the one I'm in? I read once that even a good psychiatrist can get no place without co-operation from the subject he's working on. So O.K., I don't co-operate (148).

The network of classification was underpinned and supported by other mechanisms for dealing with particular groups of prisoners. Those labelled as psychopaths presented special problems for the prison authorities. Lionel Fox described the position in the late 1940s when this group along with "the mentally subnormal, inefficient and constitutionally unstable" (149) were to be concentrated in Parkhurst:

To these 'chronic' cases should also be added those who become temporarily unstable or unduly depressed through failure to adapt to prison life, or whose reactions to discipline present special difficulties. Ideally, such a group in every prison should be under 'psychiatric management', designed primarily to improve their adaptation to present circumstances and prevent them from being a nuisance to others, but looking also to helping their re-adaptation to normal social life after discharge (150).

Fox's confident assertion regarding the identification of psychopaths was not shared by others in the medical profession some of whom were having difficulty in both defining what constituted psychopathy and how they should respond to it. In December 1954, Maxwell Jones,

writing in The Lancet provided a critical overview of the current state of affairs. He described how the adult psychopath was dealt with in a vague and indecisive way and how the category could contain groups such as alcoholics, sexual deviants, drug addicts, prostitutes and those with inadequate and aggressive anti social behaviour disorders. Again the doctors often had difficulty persuading those involved that they were in fact psychopaths:

in a severe case there is little choice but to admit such cases to a mental hospital. If the patient has come into conflict with the law he may be put on probation on condition that he obtains psychiatric treatment. With most patients this coercion is ineffective: they do not really want treatment, and they either fail to keep an appointment or never seek psychiatric advice at all (151).

Despite these doubts, for those categorised as psychopathic there could be severe repercussions. Harry Howard's account of his imprisonment in Borstal in the mid-1940s illustrates the impact of that categorisation process and the interwoven network of control that flowed from it. After escaping from Feltham Borstal he was re-captured and put in the hospital block where he immediately began to 'smash up'. For this he was put in a strait-jacket:

If you're not mad to start with, the strait-jacket will send you mad, because it's sadistic - it makes you feel so helpless. This one was the kind which has a big leather pocket inside; you put your hands down there, they strap it between your legs, and there are three or four straps that go round you, with buckles at the back. It's all right for about half an hour, while you can wriggle your fingers, but then the leather starts sweating, and your arms ache. They'd fastened it so tight I could hardly breathe, but I managed to slip a strap over a knob on the radiator, and pulled and strained until I'd released the pressure round my body and arms (152).

In 1949 Howard, still in and out of trouble, appeared once more before the Courts. A medical report described his behaviour:

for which he must be deemed responsible, had been one of rebellion against authority. He had shown a grudging and surly obedience to orders while in custody (153).

The Chair of the Court, in the light of this report, postponed sentence to allow Howard time to undergo a pre-frontal leucotomy. This operation involved two holes being bored in the individual's skull, one in each temple. Following this, a blade was pushed through the holes and the fibres that connected the frontal lobe of the brain to the thalamus were severed. It was thought, at this time, that these fibres were concerned in some way "with the intellectual and emotional aspects of mental activity, and it was believed that cutting them prevented pathological ideas from generating emotion" (154).

The operation had been developed in 1935 by Egas Moniz a Portuguese neurosurgeon. Moniz, who won a Nobel Prize in 1949, believed that his procedure worked particularly well on individuals with 'anxiety-tension states' and 'obsessive syndromes'. His technique was developed and simplified in the USA by Walter Freeman whose transorbital lobotomy could be performed in a few minutes. Using local anaesthetics he "entered the patient's brain under the eyelid with an icepick-like instrument, severing the nerves connecting the cortex with the thalamus" (155). The majority of those lobotomised were women. Freeman lobotomised 13 in one afternoon in 1948 (156).

In England, William Sargent who had earlier used insulin shock treatment to induce comas in schizophrenic patients at Maudsley Hospital,

performed lobotomies and leucotomies at St. George's Hospital in London. Along with another psychiatrist, Russell Fraser, Sargent had visited Freeman in 1939. At St. George's he and a third colleague, Eliot Slater, performed several leucotomies as well as conducting experiments with different forms of the operation. Sargent also took a sabbatical in America where he was "outraged when he was prevented by the Veterans' Hospital Administration in Washington from lobotomising fifty black schizophrenic patients at the Tuskegee Hospital in Alabama as part of another experiment" (157). Again women were the main target of these techniques. As Elaine Showalter indicates:

Sargent and Slater's widely used English psychiatric textbook published in 1972 recommends psychosurgery for a depressed woman who 'may owe her illness to a psychopathic husband who cannot change and will not accept treatment'. When separation is ruled out by the patient's religious convictions or by her 'financial or emotional dependence' and when anti-depressant drugs do not work, the authors suggest that a lobotomy will enable the woman to cope with her marriage (158).

Harry Howard described the dynamics of his operation in the following way:

I had all the hair shaved off my head till it was like a billiard ball. I was wheeled to the theatre and strapped down, because the sister said I might kick out.  
'But you put me to sleep, don't you?'  
'No, we just numb you. Your mind has to be clear for this operation.'  
They marked a blue cross on either side of my head, and the surgeon took his electric drill and started to bore the holes. As soon as he touched me I kicked like hell, and smashed the table, even though I was strapped. 'Sister,' I said, 'give me something to put me to sleep, it's terrible, I can feel it.'  
She said they couldn't and the surgeon carried on boring, while four male nurses held me down as best

they could. I couldn't see, because they'd covered my eyes, but I could feel him shove an instrument through the hole and cut something (159).

The leucotomy continued to be discussed into the early 1960s. At the annual conference of the Prison Medical Service in May 1961, the proceedings were closed with a "brief survey of the development and current views on leucotomy" (160).

This method of behaviour modification was supported by other mechanisms of control. The use of violence was one strategy that was frequently employed. Wally Probyn's account of institutional life in Wormwood Scrubs, Wakefield and Rampton in the late 1940s and early 1950s contains vivid descriptions of beatings. The Borstal boys in Wormwood Scrubs experienced "kickings by groups of warders" (161). At Wakefield, Probyn was often in solitary confinement and on dietary punishment. After being categorised as a moron under the Mental Deficiency Act, he was transferred to Rampton Special Hospital. He escaped and on being recaptured was handed over to an escort party to be taken back to the hospital. He was placed in the refractory ward where he lay in darkness for two weeks. Additionally, he was required to polish a stone-floored corridor on his hands and knees using sand and water. This continued for 12 hours a day also for two weeks:

Kneeling down for so many hours eventually made one's knees swell up to huge proportions, but one was not allowed to report sick or receive treatment. One was not allowed to stop or rest in any way, to attempt to do so would be to risk confrontation, and any confrontation always resulted in the prisoner getting a kicking from the screws. Sometimes the beatings were so severe that the

victim's face would literally be unrecognizable for many days. One of the techniques of brutality used, especially on the female side of the institution was to twist a wet towel round the victim's neck as with a tourniquet until the victim became unconscious. The female screws used this more frequently because they were frightened of getting faces marked if the victim struggled or retaliated. Thus an unconscious victim could be beaten and kicked at leisure (162).

Both Wally Probyn and Harry Howard also discuss the use of drugs to control their behaviour. While the incidents that they describe took place in the late 1940s it is clear that even then drugs were an important mechanism for controlling certain individuals within both penal and psychiatric institutions. For Howard, his transfer to a padded cell was supported by a dose of paraldehyde "to knock me out. I've had so many of these drugs in my time that if I hadn't given them up myself in later life I'd have become an addict" (163). In the case of Probyn the prison officers who were to escort him to Rampton visited his police cell and:

tried by coercion and threats to make me drink a potion referred to at Rampton as a 'sleeping draught'. The substance was used to drug particularly difficult cases. The subsequent doses were administered before the previous one had worn off and people had been kept drugged in this way for many months. A man who had been subjected to this treatment for a long period who was said once to have had an outstanding physique was, by the time I first saw him, like a fugitive from Belsen. His legs would hardly support his weight and he staggered about like a perpetually drunk man (164).

From the mid 1950s the capacity of the P.M.S. to use drugs was significantly expanded. This was due to the number of new brands that came onto the market. By the late 1950s it is clear that these drugs had a profound impact on the way that the doctors in particular



saw their relationship to the difficult and disturbed in the prisons. In the official departmental reports of the time a number of them expressed their views anonymously in unsigned statements about the drugs that were now in use. In the Prison Commissioners' Report for 1958 an unnamed doctor described how he had conducted a pilot clinical trial of Hydroxyzine aimed at the patient who was "the irritable suspicious dullard who flies into violent rages on imaginary or trifling provocation" (165). The doctor's experiment was not a complete success, the prisoners he said felt better, but the prison staff did not find it an overwhelming success although they did notice "that the boys under genuine treatment incurred as many reports as before but did not resent punishment or reprimand as they had been accustomed to do" (166). Another doctor discussed the problem of chronic schizophrenics and the use of drugs on them:

The chronic schizophrenics are our biggest problem, of whom there are always a number of cases in the prison. These men are usually unable to adapt themselves satisfactorily to the discipline of the main prison. In hospital where their condition is thoroughly understood, and where allowance is made for their eccentricities, they frequently remain for long periods without causing any trouble, and often do regular and useful work. It is not always possible to certify these men as being of unsound mind, but fortunately the introduction of the phenothiazine drugs has enabled us to control the aggressiveness and grosser eccentricities of our schizophrenic patients, so that they can lead more active and useful lives, as well as being much more contented. We have paid special attention to the treatment of the various mental disorders by drugs, as we did in 1958 (167).

A third doctor discussed a number of drugs used in his local prison. These included Tofranil, Epanutan with "epileptoid psychopaths" which gave variable results but with young people there was "a

marked improvement in behaviour generally"; Mepavalon and Pacatal which was:

given in doses up to 100mgs., three times a day. This drug has its main use in the major mental disorders e.g. in the schizophrenics, in chronic senile dementia and in the occasional agitated and disturbed psychopathic personality (168).

Chlorpromazine which operated under the trade name of Largactil, was a particularly useful drug for the doctors for dealing both with those prisoners diagnosed as suffering from mental illness and for those who were agitated and difficult to control. The drug itself had been developed by French scientists in 1952. By 1954 The Lancet could talk about its properties being "very widely studied" since that time (169). In the late 1950s both the Prison Commissioners and the doctors themselves were quite open about its use. The official report for 1958 described the use of the drug on prisoners suffering from early schizophrenia:

who were treated with a combination of E.C.T., modified with pentothal and scoline, with chlorpromazine in increasing doses up to over 100mgs. per day (170).

In the same report, an unnamed doctor described how the drug was used in his/her prison:

We have given special attention this year to the treatment of psychiatric cases with drugs. Several mild cases of depression have responded particularly well to 'Ritalin' and Meproamate has given excellent results in a number of cases showing prolonged tension. Chlorpromazine has been used on a fairly large scale with agitated patients and also in several chronic schizophrenics who were not sufficiently ill to justify certification: it continued to give excellent results

with these patients and I do not think that the other drugs which are closely allied to it and which we have tried out here have any major advantages over it, except possibly the absence of skin reactions in those persons exposed to direct sunlight (171).

In 1962 another doctor expressed similar views:

During the year an increasing use has been made of the psychotropic drugs. Largactil has been used, mainly due to personal experience of it and as a standard to compare the effect of others. It has been used in fluid form, 25mgs. being contained in a fluid oz. and the usual dosage being one fluid oz. three times a day. It has been found useful in controlling certain types of case, such as troublesome prisoners who were always at odds with authority and spent much of their time in "E Hall". Many of these cases appeared to be suffering from emotional tension and instability exacerbated by interpersonal irritations in their dealings with the staff and other prisoners. The climate situation and inaccessability for visits are further causes of resentment against authority. I have found that small doses of about 15 days of 1 fluid oz. of M/Largactil t.d.s. have relieved their disturbed behaviour and tided them over the acute phases. Some of them have taken advantage of advice from the medical staff to report sick when they feel themselves becoming tense or more than usually 'fed up'. They can then be given further help from Largactil before they resort to acts of indiscipline to relieve their feelings. Apart from its use in large doses for psychotic patients awaiting disposal in the prison hospital, there are some odd schizoid types, many with a history of having been in a mental hospital, who appear to benefit from occasional courses of Largactil and periodic reviews (172).

For the doctors then, the emergence of the drug industry and the development of drugs that flowed from it, was an important new element in their medical armoury. The distinction between treatment and control, became increasingly blurred as they saw the benefits that could be derived from such technological developments. Writing in The Lancet in December 1961, two P.M.O.s described how they saw the use of drugs as a replacement for the older, more

traditional methods of control, including the strait-jacket:

it may well be possible and it would certainly be desirable to abolish them although that is not to say that some modified form of restraint may have to be retained for use as a temporary measure with violent patients until the drug of choice has begun to take effect (173).

This development is explored more fully in Chapter 5. For the moment, it is necessary to note that while medical and psychiatric interventions into the lives of prisoners was extensive and expanding, medical hegemony was neither complete, nor was it given the respect and legitimacy that many of its practitioners felt their profession deserved. The resistance of prisoners has already been documented. These practices were also challenged from within by other state servants most notably by the prison officers who since the war had felt that prisoners were being increasingly pampered and that their control was being usurped (174). This usurption, was compounded by the intrusion of outsiders such as psychologists into the prison service. When it met for its annual conference in Belfast in May 1952, the Prison Officers' Association was deeply concerned about what a resolution called the "serious effect of growing indiscipline on the well-being and efficiency of the prison service" (175). J. Blow, the delegate from Wandsworth Prison told the Conference that they had now seen the advent of the psychiatrist and others "who do not help one iota in maintaining discipline. In fact we are of the opinion that this treatment tends to pull the other way" (176). The more self-critical psychologists were also aware of these problems, although they often were lost in the general drive towards the establishment of psychology as the pre-eminent and scientific body of knowledge for explaining and dealing with criminality. Elda

Thomas, who worked at Ashford Remand Centre and at Wormwood Scrubs in the early 1960s discussed the problems of the new entrant into psychological service in the prisons. These included the fact that often the psychological needs of the prisoner "come a long way after other considerations when decisions are made - the needs of the institution, work, home, type of offence taking precedence" (177). Thomas went on to describe how the staff regarded the reports of psychologists:

as of little relevance ..... Officers fear that psychologists are soft, senior staff fear the psychologist will usurp their authority ..... These suspicions and hostility (sometimes barely concealed) do not seem to be personal in any way, but seem to be part of a more extensive and more serious problem that of paranoia which institutions of this type engender in all those involved in them (178).

This challenge to the authority of the doctors and psychologists was not simply an internal matter that occurred behind the prison walls. Beyond the confines of the prison, other voices were to be heard calling them to account for both their role and their actions inside. These voices contested the claims of the prison managers that the conditions in which the P.M.S. operated and practices that medical personnel carried out were scrupulous in their adherence to the Hippocratic oath. The work of prison reform groups in the post-war period articulated a different reality.

#### Prison Medicine and the Challenge from Without.

The challenge to prison medicine and psychology from beyond the walls should be seen in the context of the wider debate concerning the

impact of secrecy on the penal system. As Chapter 4 indicates since the centralisation of the system in 1877 when the state assumed responsibility for the control and administration of prisons, these institutions had, as Sydney and Beatrice Webb pointed out, become secret places (179). Information was strictly controlled by the managers of the system. Consequently, within the public domain, debates about penal policy rested on the information provided by those whose job was not only to manage but to be seen to manage that system efficiently and without difficulty. Challenges were defused by denying information to those outside the walls interested in penal policy and to those inside, namely the prisoners themselves, who might wish to protest about the state of their confinement. Prisoners could protest about certain aspects of their confinement but only within the confines and parameters laid down by state servants. In that way, secrecy and censorship were two corner-stones in penal policy geared towards individualising prisoner protest inside and frustrating the emergence of support networks outside the walls. The work of James Michael and David Leigh has strongly emphasised the importance of such secrecy for the emergence and consolidation of modern state institutions (180). There is, however, one crucial, though rarely identified, qualification to be made with regard to such analyses, namely that there were challenges to this secrecy. The secret state did not develop uniformly or evenly but as with all other aspects of state formation and policy implementation, secret practices have been subject to frequent challenges and occasional defeats by those who have been the object of their domination.

In 1922 Stephen Hobhouse and Fenner Brockway published English Prisons Today. The book was a massive 728 page analysis of the state of English prisons in the period 1914-1919. Hobhouse and Brockway were members of the Prison System Enquiry Committee which had been established in January 1919 by the Executive of the Labour Research Department. In the Foreword to the book they pointed out that not only had there been no systematic enquiry into the prisons since the Gladstone Committee of 1894-5 but that information concerning the working of the prisons was proving increasingly difficult to obtain:

The Enquiry has had to face the initial difficulty of the secrecy which surrounds the prison system. It is practically impossible for the public to obtain entrance to prisons or knowledge of what goes on inside them. The Prison Commission itself is one of the most secluded of Government Departments. The Commissioners publish annual reports but (more especially since 1915), the information provided is scanty, whilst the published code of prison rules gives little indication of the actualities of the prison regime (181).

The Committee itself included magistrates, retired prison officials, penal reformers, doctors, lawyers and ex-prisoners. To obtain information they submitted a questionnaire to and interviewed 50 prison officials including chaplains, medical officers and prison officers to which they added the evidence of 34 agents of the Discharged Prisoner's Aid Society, 22 visiting magistrates and 290 ex-prisoners. Hobhouse and Brockway had themselves both been imprisoned as conscientious objectors during the First World War and along with other anti-militarists recorded their experience of prison. So too had a number of suffragette women.

Hobhouse and Brockway devoted a number of chapters to the health of prisoners, the treatment of the sick and the conditions in which treatment was applied. Their analysis covered a whole range of areas, issues and controversies in relation to prison medicine including the effect of imprisonment on health, the question of deaths in prison, the role of medical staff and their relationship with prisoners, the issue of malingering, the adequacy of medical staff, the treatment of specific complaints and the use of solitary confinement in prison hospitals:

There was an old man, sixty years of age, suffering from acute rheumatism. He served the whole of his eighteen months' sentence in hospital, and during the six weeks that I was there he was confined to his bed in his cell the whole time. There was a second old man of seventy years of age who served a twelve month's sentence in a hospital cell and there was a tubercular patient (afterwards removed to die in Woolwich hospital) who remained all day in an ordinary hospital cell - although in his case the door of the cell was left open. Anyone with a little imagination will appreciate what physical and mental torture such treatment involves (182).

They discussed in detail the impact that the conditions inside had on the health of the prisoners, particularly the question of sanitation. Again prison hospitals were a cause for concern, sanitary arrangements being described as "very inadequate" (183). The evidence of ex-prisoners testified to the state of these arrangements:

In hospital no provision was made in the cell for washing plates or mugs and it was the custom for prisoners to take them to the recess when they were allowed out of their cells to empty their slops. In the recess there was a W.C., a very small sink used exclusively by the cleaner and a bath. The bath was used for the washing of plates and mugs, porridge dixies - and chambers. I have frequently seen a prisoner washing out his chamber at one end of the bath, whilst a second prisoner washed his plate and mug at the other end. This was a daily occurrence (184).



Such criticisms were to be revived and renewed in the 1940s with the establishment of the Prison Medical Reform Council, on whose executive committee sat Fenner Brockway. During the decade, the Council published a series of reports which directly challenged the accounts of the Prison Commissioners by highlighting the kind of medical treatment that prisoners received inside.

In 1943, the Council published the report of an enquiry that had been conducted by its secretary Roger Page. The enquiry centred on medical services in prison. Page himself had experience of imprisonment having been sentenced as a conscientious objector during World War 2. The report, called simply Prison Medical Service, was the first full-scale account of the Council's research to appear in written form. The Council itself was sponsored by what Page called "many people prominent in our national life" including MPs Rhys Davies and Reginald Sorensen, the Duke of Bedford, Lady Claire Annesley, Vera Brittain, Compton MacKenzie, Fenner Brockway, Stephen Hobhouse and Victor Gollancz (185). The group had identified "grave defects in the Prison Medical 'Service'" (186). As the evidence of these defects grew:

[and] came in from all quarters it became increasingly plain that here was a scandal to which public attention should be drawn. So there came into being the Prison Medical Reform Council, an organisation formed by a group of people who have a concern for the well-being of their fellow-citizens and who by calling this Council into being, exercised their democratic right to criticize public administration (187).

This Council's object was to press for what it called the "proper working of the Prison Medical Service (which shall be interpreted as being responsible also for hygiene and mental health) and

for extensions and improvements therein" (188). In a foreword to Page's pamphlet, Compton MacKenzie, situated this concern with the P.M.S. within the general context of liberal reform in the prisons:

Great liberals fought hard in the past to put prisons under the control of a more enlightened administration. They must fight equally hard to ensure that the administration that they brought about keeps pace with contemporary thought. No path is more difficult to light up than the path of penal reform because the lamps are so easily extinguished by those whose interest it is to keep it dark (189).

When imprisoned Page discovered a submerged world that deeply disturbed him. The medical treatment that prisoners received was a particular source of concern. He argued that when discussing the P.M.S. the word service should be printed in inverted commas, that the authorities assumed every prisoner was a malingerer and however ill an individual might be, it was never forgotten that he/she was a prisoner. In addition he discovered:

day-to-day medical care was of the most perfunctory and casual kind imaginable; and that the regulation medical examinations were the merest matter of form, often only a glance or a question. I discovered that provision for dental care was callously inadequate. I discovered other things .... (190)

Amongst these "other things" were the conditions in which medical treatment was given. At Wandsworth, where he spent  $3\frac{1}{2}$  weeks, Page found that during the whole of this time one of the recesses on his landing was out of use. This meant that there was one recess for 45 men for emptying their overnight "slops". This led to both a "vile stench" and the blocking of either the one sink or the one

W.C. that had to cope with these numbers.

Prisoners also had to pay for medical services. Teeth would be extracted, for example, by a dentist who visited the prison, on payment of half-a-crown (12½p) per tooth. If prisoners were not in credit then the work would not be done. Fellow prisoners who had the money could not provide assistance. Page's initial research was supported by evidence which he obtained from a questionnaire that was given to other conscientious objectors. The answers were overwhelmingly critical of medical services and the conditions inside the prisons. As he maintained "I have declared the Prison Medical Service to be shamefully inadequate. Here is the evidence to support the statement" (191).

This conclusion was supported by a number of other pamphlets produced by the Council. In 1943, it published the 24 page pamphlet, Prison for Women: Some Accounts of Life in Holloway. Again much of the content concerned medical treatment inside, in this case in relation to women. Barbara Roads, one of the contributors, described her experience:

The medical examination is so superficial that it is a wonder that any disease is ever diagnosed .....  
[Pregnant women] have ordinary prison diet until 6 months pregnant and then have extra only 2 slices of bread and half-a-pint of milk each day. They spend 23 hours of each 24 sitting or lying down .....  
They are locked in their cells each night in solitary confinement right up to the time the baby is due.  
The ruling on this matter is that the expectant women are to be moved to hospital when 8 months pregnant but this was not done while I was at Holloway; the hospital was full (192).

In 1944, Page himself wrote a Prisoners' Medical Charter which was a 10 point plan for the improvement of medical provision inside. Again he concentrated not only on the kind of treatment but also the conditions in which the treatment took place. The pamphlet once more pointed to the treatment that pregnant women received in prison and compared this with the treatment that those on the outside received. These women, Page argued, were encouraged to have cod-liver oil, extra milk and orange juice which were all provided cheaply through schemes subsidized by the state. The same advantages should accrue to women in prison, as well as classes in 'mothercraft' and on ante-natal care where the number of prisoners warranted it:

Until far advanced in pregnancy, women, usually, are subject to the normal prison routine which involves being locked up in solitary confinement for long periods including the hours of darkness. Because of the bad psychological effect and the difficulty of getting emergency attention, this state of things should be altered (193).

The Council also highlighted the experiences of individual prisoners. In October 1945, it published The Case of Prisoner Alpha. This was a 13 page pamphlet which dissected the prison life of a 24 year old prisoner who suffered "from severe, permanent, incurable epilepsy" (194). Alpha's problems were compounded by the fact that he had no teeth, had lost his spectacles in prison and had petitioned the Home Secretary about his plight. Because of this, he was victimised, a charge denied by the Home Secretary. Amongst the threats was one from a hospital officer who told the prisoner that if he came into hospital "he would 'know all about it' - he would 'be unlucky!'

When Alpha said he had already been there once as a patient the reply came: 'Yes but we didn't know all about you then'" (195).

As late as 1962, the Council, now renamed the Prison Reform Council, was still publishing pamphlets and submitting reports to the Prison Commissioners. In August 1962, it published Inside Story which was described as a report submitted by a "group of ex-prisoners to the Prison Commission drawing attention to discrepancies between policy and practice in penal administration" (196).

The report contained fifteen proposals under the general heading of "medical". These proposals centred on questions of recruitment, the "don't care" attitude of prison staff, the issue of the perfunctory nature of medical examinations on admission and the diet for pregnant women which it was argued was "not up to the standards generally recommended outside" (197). It also called for an inquiry into:

the practice of young girls ..... slashing themselves in the arm when in a state of frustration and rebellion. This is clearly a symptom of mental disorder but because it is so general inside it seems to be regarded with surprising complacency at lay level (198).

The Council's accounts of medical treatment in the post-war period was supported by other publications and organizations at the time. In 1948, Charles Carter edited the 28 page pamphlet Snail's Progress which highlighted the experience of Quaker prisoners between 1939 and 1948. For those prisoners, the war years in particular, meant that the small advances made in the pre-war era had been swept away

as regimes were tightened up. Again the standards of hygiene and the conditions inside were a particular focus for concern; twenty men having to slop-out in blocked up water closets; the difficulty in obtaining toothbrushes, combs and toilet paper; prisoners having to spend five weeks without a change of socks, shirt or towel; Wandsworth prison being infected with bugs in the bed-boards. Once more, the medical conditions were a cause for concern:

The medical inspection on admission is often quite trivial and the examination on discharge even more perfunctory. Sometimes the newly admitted prisoner is not even required to undress ..... Though occasionally a prisoner speaks well of the diet, the food is often poor and badly prepared with too little in the way of fresh fruit or green vegetables; and none is served between 4pm and breakfast (199).

The autobiographies of prisoners were also filled with critical comments on the standards of medical care. In 1954, Peter Baker the youngest MP in the House of Commons was sentenced to seven years imprisonment. His autobiography Time Out of Life, first published in 1961 provided details of his imprisonment in Wormwood Scrubs and in particular his employment as a prisoner/worker in the hospital. This gave him the opportunity to study the medical services at first hand. Baker felt that the whole procedure for reporting sick was unnecessarily cumbersome and that the attitude of the doctors on morning sick parade "was little short of scandalous":

The reputation of the medical services throughout the prison could hardly have been lower. Those reporting sick were said to be treated cavalierly or not at all and some were refused treatment when suffering with what later proved to be serious illness. A prisoner

called Hardy had just died of neglect. Poor Hardy kept falling off his work-bench and lying unconscious on the floor. The doctors, without giving him a thorough examination, reported him as a malingerer. For this, he was constantly harried, despite recurrences of his black-outs. Very shortly afterwards, he was dead. He had a tumor of the brain. I was determined to see the whole picture for myself (200).

Baker described how he himself had been treated as a malingerer and how the doctors, with one notable exception appeared to "regard their task as the promulgation of discipline rather than of medicine" (201). Finally he described other uses to which some cells were put in the hospital wing:

I also remember with some bitterness and regret the treatment meted out to patients, particularly boys, who became violent or troublesome. These were nearly always shut in a padded cell and then given a severe and scientific beating-up. Although their cries and screams of pain could be heard throughout the hospital, this was always excused on the basis that the process was the best medical remedy for hysteria. My own feeling was that, on the one hand, many of the patients so indiscriminately treated were not cases of hysteria, and that, on the other hand, there must now be more humane treatment for hysterics. In many instances, these men and boys were simply difficult disciplinary cases, brought across to the padded cells especially for the beating-up (202).

The medical establishment also contributed to the debate about conditions inside. On 4th August 1945, The Lancet's anonymous writers responded to the new Home Office publication on prisons and Borstals. The journal reaffirmed its support for the rehabilitative ideal - we should train the offender afresh in citizenship - as they put it. At the same time, it reminded readers that much more needed to be done. In particular, "from the medical point of view there are several defects about which the Home Office ..... seems to be unduly complacent" (203). The journal was also concerned

about what was thought to be a probable deficiency of vitamins which particularly affected long-term prisoners. This situation was made worse by the fact that restrictions could be put on the diets of those who were disciplined or punished:

A man may be put on bread and water for 3 days at a time or for 21 days on bread, porridge and potatoes, and these punishments may be repeated after he has been back on full diet for 3 days and 7 days respectively. This form of Victorian nursery punishment, together with flogging, and removal of a man's mattress for 15 days might well be relegated to limbo now that we have agreed that we wish to build up a prisoner's self-respect, not to deplete or degrade him (204).

The journal pointed out that there had been progress in meeting the needs of men and boys but that this progress "greatly exceeds" that which had been made for women and girls. The writers hoped that the appointment of Dr M.D.C. Taylor, a woman, as governor of Holloway "will mean a rapid advance." I shall return to this question of women in prison in Chapter 6 below.

The question of a suitable diet for prisoners and what was sufficient to maintain them was also a source of controversy. It was one in which the doctors were intimately involved, particularly with regard to those prisoners who had been punished by being placed on a restricted diet. This central element in the work of the doctors, and its historical roots is explored in greater depth in the next chapter. For the moment, it is important to note that this controversy in the post-war period also raised serious questions not only about the treatment of certain categories of prisoners but the role of the doctors in that treatment.



On 8th February 1947, The Lancet carried a long editorial entitled Justice and Prison. The editorial discussed the rising crime rate amongst the young, and the dissatisfaction that was felt with approved schools and Borstals, particularly the high recidivist rate amongst young girls where 638 had been discharged between 1938 and 1942 but "31.5% have already been convicted again on two or more occasions and only half have avoided a reconviction" (205). The editorial pointed out that Magnus Pike had investigated the diet of prisoners during those years. He had found that in all prisons and borstals there was a shortage of fat in the diet and that "dried eggs were excluded except for hospital use which indicates that the Commissioners estimate nutritional needs at a lower level than set by ordinary rationing" (206). In January 1948 Chuter Ede, told the Commons that with an extra allowance of 14 oz. of potatoes a day, the over-all value of the diets for prisoners, "approximated to the average for the whole population but was less than the value of the diet of an ordinary male worker" (207). By November 1949, the over-all average calorific value of prison diets was 3192. There were variations however within this general category between local, regional and prisons for young people, between men and women and between boys and girls. For men in local prisons for example, the figure was 3,126 for women 3,015, in regional prisons it was 3,438 and 3,015 respectively, for boys it was 3,306, for girls 3,155 (208).

*These conditions and regimes were not readily accepted by the prison population. As I indicated above, there were a series of demonstrations and disturbances in the post-war prisons. In the case of the prison diet, the demonstration at Parkhurst in December 1947, in which*

105 men took part, provides a good illustration of localised forms of resistance to particular forms of domination.

Medical power within prison therefore did not remain unchallenged during the immediate post-war period. There were a series of conflicts between medical personnel and the confined, between doctors, psychologists and other state servants, and between the Prison Commissioners and outside support groups. All of these conflicts were inter-related and were fought out both at an ideological level in terms of how definitions of criminality and prison regimes were understood in post-war Britain and at a political level in terms of direct action in the prisons themselves. This meant that doctors and psychologists did not have unlimited and uncritical access to the bodies and minds of the confined for while their influence and power clearly increased, the institutional impact in terms of day-to-day practice was circumscribed by these conflicts and struggles. As Nicos Poulantzas has pointed out, such struggles are a central, and ever present aspect in the everyday manifestation of State power:

Such struggles are always present in the State (and, more generally, in power mechanisms); for even though the State is already there, neither the State nor power is the First Cause of struggle. Struggles are inscribed in the strategic field of the mechanisms and apparatuses of power - that is to say, political struggles which bear upon the State in its peculiar strategic field without necessarily being 'integrated' into the power of the dominant classes (209).

In the 1950s, conflicts were still apparent and were underpinned by the more general questions of treatment and training, classification and control. Serious doubts were still raised about the efficacy of

psychological and medical practice. Despite this, the doctors and psychologists continued to demand, and often received, an increasing say in the definition and treatment of the criminal and the deviant. That demand, as I shall illustrate, was not only based on the dubious theoretical ground of sociological and psychological positivism but once more was subjected to the critical scrutiny of those at the other end of the batteries of bricks, blocks, intelligence tests and hypodermic needles. It was a conflict which by the mid-1960s was to become even more intense.

#### Into the 1950s: Defining the Deviant.

Many of the themes identified above in the immediate post-war period relating to criminality and deviance, persisted into the 1950s. Heredity and environment, usually in combination, were the corner-stones of the debates over how crime should be understood. These arguments were given an air of greater subtlety through the development of what appeared to be scientific methods for measuring and predicting criminal behaviour. The 1950s was to see a proliferation of research projects, overwhelmingly forensically based, which continued the search for the elusive golden fleece of criminological endeavour, the cause of crime. Once more, those who spoke for the society saw the rise in crime as a more general threat to the social order itself. If the cause was not found, and a cure implemented then that order was in danger of collapsing under the sheer weight of criminal practices.

In October 1953, the Nuffield Foundation invited Lord Pakenham to "undertake a critical appraisal of current views of the causes of crime" (210). The purpose of the inquiry was to look at the diverse opinions which were held about the main causes of crime and to attempt to reveal subjects "which would repay further close examination" (211). The make-up of the inquiry team provided an indication of what these subjects would be. First, the Home Office, Scottish Office and Ministry of Education were to help with advice and information. Second, Pakenham was to be assisted by a small group of assessors including the psychiatrist Dr Desmond Curran, the forensic psychiatrist T.C.N. Gibbens, the Metropolitan magistrate Frank Milton and the criminologist from Oxford University Max Grunhut. The forensic thrust of such reports was supported by conferences which like those in the 1940s were attended by a group of like-minded forensically based experts eager to discuss their views on crime causation. In March 1954, the International Society of Criminology, the British Council and UNESCO organized a two week course in London. The theme was Recent Advances in the Study and Treatment of Offenders. It was directed by Dr Dennis Carroll, the President of the International Society and by Hermann Mannheim who was now a reader in criminology at London University. Among the medical contributions was a paper by Dr Dennis Hill, a senior lecturer in clinical neurophysiology on electroencephalographic studies. Hill claimed that with the exception of possible birth trauma and other forms of brain disease "all evidence at present indicated that E.E.G. patterns were primarily determined by heredity" (212). Hill was later to sit as a member of the Gwynn inquiry into the P.M.S. established in 1962 by the Home Secretary which is

discussed below. Other papers included a contribution from Dr Sessions-Hodge, a consultant psychiatrist to the South Western Regional Board who discussed the hormone treatment of sex offenders, including homosexuals. Sexual offences he explained could be regarded as being due to a "lack of balance between primitive drives, probably originating in the hypothalamus and other lower brain centres, and the inhibitory effect of the cerebral cortex which normally inhibited them and ensured that they received only socially and ethically acceptable outlets" (213). There were also papers from P.M.O.s including one from Harvie Snell, the Director of the P.M.S. on the subject of psychotherapy in prison and another by Dr Ogden the M.O. at Portland Borstal who spoke on the subject of Typological Research on Adolescent Offenders (214).

Inquiries such as Pakenham's and conferences such as that organized by Carroll and Mannheim were important meeting places for intellectuals and practitioners to discuss, debate and disseminate ideas concerning the latest forensic research. Such ideas extended beyond the narrow confines of the conference hall to the pages of prestigious medical journals such as The Lancet and the British Medical Journal, as doctors and psychiatrists used their columns as platforms to further reinforce the positivistic view of criminality.

In June 1955, The Lancet in a leading article, cited a speech made by Sir David Henderson to the Royal College of Physicians under the auspices of the Morison Lecture. Henderson argued that the aetiology of criminal behaviour was complex and that it should include understanding not only parental attachments but also constitutional factors - hereditary, developmental, endocrine and metabolic.

As the authors pointed out, Henderson felt that:

Separation from the mother in the early years may indeed be one such factor but can hardly be the only one: in fact criminal behaviour, he suggests, is not a symptom but a reaction - type - 'a social reaction type if you prefer it, but still a psycho-biological reaction dependent on our particular make-up, however, it may have been forged (215).

Homosexuals, once more, were a particular concern, their 'tendencies' being seen as dependent on "a failure to develop and mature, the patient remaining fixed at a homosexual level". They were a "developmental disaster ..... people who have reached neither emotional nor instinctual maturity, even though they wear the mask of sanity" (216).

For abnormal offenders, Henderson recommended indeterminate detention, particularly for those accused whose life history "shows evidence of malignant trends". Finally, he urged:

the great need for more intensive investigation of character traits, so that we may in time be able to distinguish their diagnostic and prognostic significance. Forensic psychiatry would then be in a position to point to particular clinical and psychobiological reaction, whether dependent on genes or derived from the environment (217).

The Lancet also gave space to other views which emphasised environmental factors in the production of criminality. It was a particular notion of environment centred on the family once more, and the role of the mother in particular. In September 1958 the journal cited the work of I. Galdston (along with Arthur Jensen) as deserving of careful consideration. Galdston argued that crime and delinquency could be blamed on the decline of the family and to

the fact that:

Modern technology and social circumstances have emancipated the mother to the point where she no longer needs to bake the bread, weave the cloth, feed the chickens and teach the children, nor does she (as the father must) earn the money. She is free to build up a dominating position within the family, and to wreak havoc in the children by over-protecting them and ousting the father as the principal figure (218).

The writers of the article also pointed to the work of the Gluecks in America and to the 1957 Report of the Metropolitan Police in England as supporting evidence. Both had argued that fathers of delinquents tended to be incompetent, lax in discipline or in the case of war babies there was a lack of "even an incompetent father." The journal concluded that:

Much has been written about the so-called sick society (was it ever healthy?) and surely there can be no simple answer to the complex troubles of a complex civilisation. Admittedly Galdston begs many questions ..... But challenging views such as his are needed if only to stimulate further social and anthropological studies. A careful examination of the patient has long been held to be a useful prelude to effective treatment (219).

The Lancet was pessimistic about what would be done about crime. In its review of the Criminal Statistics for 1957, its writers pointed out that crime was increasing and the general picture for the year was 'gloomy'. They felt that crime was too wide and too nebulous to have a single cause but that it could be prevented. The first step on this path and the 'greatest single need' was for:

operational research units whose task it would be, not to seek out the probably indefinable causes of crime, but to develop techniques for handling par-

ticular types of offenders, not necessarily in special institutions but as far as possible within the framework of their present social background (220).

In January 1961, The Lancet published another leading article which reviewed the 'origins of crime'. Once more the journal cited the work of leading sociologists and criminologists of the day including research by John Barron Mays in Liverpool and William and Joan McCord in America who pinpointed the importance of strained relationships in the home as a source of delinquent activity. The work of the McCords confirmed the earlier studies by the Gluecks who argued that home background was of predominant importance with "cohesive homes producing few criminals and quarrelsome and neglectful homes many" (221). Of all the influences studied, they concluded that:

the mother's personality seemed to be the most significant in the genesis of criminality. Maternal passivity, cruelty, neglect and absence were all associated with a high degree of all types of criminality. On the other hand, maternal love, even if complicated by an overprotective attitude, by anxiety, or by neurosis, was generally associated with low rates of crime ..... the father's personality was also found to be of great importance, and paternal absence, cruelty, or neglect tended to produce criminality in a majority of boys (222).

Once again, the family became a central focus of attention and a point of intervention for state welfare personnel into the body of society. Research by professional psychologists and criminologists appeared to confirm the causal relationship between family disorganisation and criminality. John Rich's study entitled Types of Stealing and published in 1956 emphasised that his statistical and clinical study of 200 young male thieves showed a "firm association between parental rejection and stealing from home" (223). Boys who



had been separated from their parents early tended in Rich's view to be unhappy and to engage in "impulsive solitary pilfering away for home" (224).

In 1958, a monograph from the Office of the Chief Psychologist at the Prison Commission once more emphasised the family background of the criminal, although this time, there was also a class factor involved. Outlining what was termed a working-class, middle-class criminality dimension, the author argued that:

for each type of criminality there is a different type of bad home background. Thus with each type of middle-class criminality, fraud and homosexuality, there is associated respectively, spoiled by father and dominated by mother; whilst in the background of the common criminal the following variables are relevant: alcoholic father, rebellious attitude to father, rejected by mother, inter-parental quarreling and inter-sibling jealousy. The common criminal has quite clearly come from a highly inharmonious background (225).

These views were supported not only by this internal research, but also by research conducted outside by criminologists and sociologists. In 1951, Cyril Burt reviewed Juvenile Delinquency. It was written by Sheldon and Eleanor Glueck and Burt's review appeared in the British Medical Journal. The influence of innate and genetic factors was considered by the Gluecks to be important so that delinquents belonged to the mesomorphic type popularised by Sheldon in the 1930s. This meant that they had a physique in which there was a relative predominance of muscle and bone. The delinquents did not use abstract thought processes such as reasoning or reflection, while their mean IQ was found to be 92. These individual factors were related to wider environmental factors:

Their parents tend to be inferior in almost every respect - physically, intellectually, emotionally and morally. Delinquency itself is thus nearly always the outcome not of any single pathological trait but of a plurality of converging factors. It will be seen that these several conclusions agree to a remarkable extent with those already reached by British psychologists who carried out similar investigations in London and elsewhere (226).

For Burt, the Gluecks' research was admirable both in its planning and implementation. It formed a model of its kind. As importantly, were the detailed tables of the findings given in the appendices. The Gluecks claimed that by using similar statistical calculations developed around 'psychological and social assessment', it should be possible "to predict at or soon after the age of entering school, which children are most likely to drift into delinquent habits and to substitute preventive methods for curative" (227).

The Prison Commissioners discussed the problem of crime causation at a higher level of generality which emphasised the expansion of professional services to intervene into the criminal's life and background. They preferred to stress the general inter-relationship between individual and environmental factors arguing that "if crime is to be regarded as a biological, psychological and social problem, it follows that those offending against discipline should be studied by experts in these fields" (228). To that end, particular prisons such as Brixton and Holloway had a web of professionals directed by principal Medical Officers and supported by several M.O.s, a psychologist, a psychological tester, a psychiatric social worker, hospital officers and nursing sisters. With such teams, the Commissioners explained "it is possible to offer the Courts authoritative advice based on thorough individual studies" (229). By the mid-1950s the

problem of professional under-staffing still remained. This staffing provided the key to the study of the individual criminal and in particular "to the extension of early diagnostic interviews and the more intensive investigation of convicted inmates ...." (230). While the Director of Medical Services pointed to the slow but helpful increase of skilled staff since the war, especially in the creation of the psychological department which was expected to make an increasingly valuable contribution as it gained more experience, he nonetheless felt that "there remains a wide scope for an expansion of this work" (231).

The Commissioners also listed the kind of research that was being funded throughout the 1950s and who was receiving permission and given facilities to engage in it. In 1952, two researchers from the Institute of Education at the University of London were given facilities to conduct "intellectual tests on young prisoners at Lewes to enable them to complete the experimental stage of a research scheme on the deterioration of mental alertness and flexibility among adolescents and young adults" (232). In the same year, permission was given to T.C.N. Gibbens of the Institute of Psychiatry to conduct research the aim of which would be to assist in the drawing up of methods of prediction, to arrive at a more accurate determination of the percentage of psychiatric cases amongst Borstal prisoners and:

to determine on the basis of these tests whether a number of Borstal lads fall into particular groups and then, by comparison, if possible, with a control series of non-delinquents to decide whether the factors present in the groups can be regarded as causative of delinquency (233).

In December 1953, the Institute for the Scientific Treatment of Delinquency (ISTD) published its annual report. The report listed the research projects it was sponsoring including a statistical study of 250 delinquent boys aged 7-17 and a study of the effect of oestrogens on sexual offenders. With the Howard League, it was conducting a short investigation into cruelty to children for which the Prison Commissioners had given facilities for the psychiatric examination of those who had been sentenced during the previous year. There was also a concurrent study being carried out on the social economic and cultural background of families in which cruelty occurred. Finally, the annual report was also keen to publicise the different courses with which the ISTD was associated. These included lectures in the new diploma in sociology at London University, arranging week-end courses on delinquent and criminal behaviour for psychiatrists, offering study courses for magistrates, assisting with the Home Office courses for probation officers in training and arranging lectures for prison officers (234). In 1956, the study by Hermann Mannheim and Leslie Wilkins concerning prediction techniques was thought to be of sufficient importance to "justify continuous validation and development of these techniques and the possibilities of their practical application" (235). Wilkins himself, addressed the annual conference of the P.M.S. held at the Home Office in May 1956, directing his remarks particularly to the psychologists (236).

Mannheim was also involved in a number of other projects including a study of the use of imprisonment by magistrates' courts and two studies of group relationships in prison (237). Finally, in 1958 it was reported that the Institute of Psychiatry at Maudsley Hospital

was studying the application of "personality tests to prisoners at Wandsworth prison with a view to investigating the use of these tests in the prediction of recidivism" (238).

Prediction techniques and the use of scales were seen as keys to the problem of identifying the criminal. The Lancet praised the work of Hermann Mannheim and Leslie Wilkins in this area:

Those with clinical leanings may be repelled by this apparently mechanistic technique, but the firmly scientific attitude preserved throughout the book is vindicated by the prognostic success achieved. A chapter giving full case-histories will gild the pill for the intuitive psychologist and make more acceptable a text which should serve as a useful work of guidance and reference to doctors or laymen interested in the prediction of human behaviour (239).

The British Medical Journal expressed similar views. In November 1958, under the title of Disordered Society, the journal discussed the increase in crime which was half as much again as before the war with a "disturbingly high number" being committed by youths between 16 and 21 (240). The Home Secretary had pointed to the lack of knowledge in the area which hampered the work of the police and courts. The BMJ cited the work of the Institute for the Scientific Treatment of Delinquency as a good example of the clinical work that was being done under the directorship of Mannheim. The Institute argued that crime was a form of behaviour disorder to be correlated with other social and psychological disorders and to be treated along similar lines. As the BMJ pointed out, it was:

logical therefore for the Institute to press for the establishment of "observation centres" where selected offenders could be diagnosed and treated. By encouraging research on these and other lines

the Home Secretary might not in the future have to give such a depressing account of what he called "a deep disorder in society" (241).

This message had been articulated three days earlier in the Queen's Speech to Parliament when she outlined the government's proposed legislative programme and its response to the crime problem. She pointed out that it was viewed by the government with gravity. In the light of the most up-to-date knowledge and research "they will seek to improve the penal system and to make methods of dealing with offenders more effective" (242). To that end the Home Secretary proposed that more precise methods of classification were needed "to remove the jumbled grouping together of prisoners of all kinds .... [and to] endeavor to secure more adequate treatment of the prisoner as an individual" (243).

The kind of research which the Home Secretary was proposing once more involved criminology and criminologists. The expansion of the discipline was supported by the medical establishment as helping in the fight against crime. In August 1961, in a long leading article entitled Aims of Criminology, the BMJ argued that criminology had a "genuine contribution to make to the behavioural sciences though as a field of study rather than a science in its own right" (244). The authors argued that the "medical man and especially the psychiatrist has an important part to play in criminological research" (245). In particular, the journal felt that such men were able to draw attention to the differences in temperament, physique and mental health which made some individuals "particularly susceptible to inimical social influences; and may guide his more arithmetically minded colleagues away from exclusive preoccupation with easily

measurable factors, like housing and income, towards the more subtle and perplexing questions of emotional life" (246). They were thus encouraged to see that the newly established Institute of Criminology at Cambridge, through which much of the new research was to be conducted and which could not "fail to exert a considerable influence on research in Great Britain, includes a psychiatrist and a psychologist among its research staff" (247).

#### Prison Medicine in the 1950s.

The interests of prison medical workers in the 1950s in terms of explaining criminality reflected the themes outlined above. Doctors and psychologists inhabited a universe where criminality overlapped with notions of moral underdevelopment, personality inadequacy and lack of adjustment to the wider society's norms. In the Prison Commissioners Report for 1953, an unnamed psychologist observed that the most striking change in the prison population had been in the quality of the personality of the average prisoner who "is poorly integrated and shows great poverty of the whole personality" (248). This "poverty" manifested itself in a number of different ways including lack of foresight, little determination or moral courage, lack of interest, petty and unpredictable behaviour:

Even open revolts against discipline lack determination and drive ..... The general picture is that of unreliable, ill-disciplined lads, negative rather than positive in their outlook and personality traits, with little to "work on" from the training point of view (249).

Two years earlier, a similar picture of moral depravity was painted by R.S. Taylor the psychologist at Reading jail and a member of the prison's allocation board. Despite his admission that this was his "first experience of prison work" Taylor was very precise about the roots of criminality: truancy, poor work record, bad time-keeping, faulty attitudes to work and once more a poor home environment:

So often in the home there had been death or separation of one or both parents. Homes had been situated in poor overcrowded areas and frequently the men came from a large family of four or more children of whom they were, as far as could be ascertained, the only ones to be in trouble. Quite often the father was disabled or periodically out of work and the mother harrassed and overburdened had to go out to work and was unable to deal effectively with the problems created by a large family ..... A fairly high percentage of the men passing through Reading might be classed as social inadequates, and although an accurate figure cannot be stated it is probably in the region of 65 percent. In these cases many early causative factors may be distinguished but almost invariably unsatisfactory parental relationships are prominent and these are reflected in the man's present self attitudes (250).

Similar views were expressed in the 1955 report where one psychologist talked about the criminal's failure "in the acquisition of basic adjustive techniques." Once again this manifested itself at the level of immorality. Therefore it was "not poverty but the failure to spend wisely; not lack of moral discipline but the failure to regard this as just and reasonable and necessary to social welfare" (251). The Commissioners themselves repeated these views in 1957 in their summary of the reports from the Governors of the training prisons who had reported on what they termed a "falling off in the quality of men" that had come from the local prisons during the year. This manifested itself through "irresponsibility and a passive acceptance



of benefits without efforts towards self-improvement [which] are characteristic of an increasing number" (252).

As in the 1940s, both the Commissioners and the doctors saw the key to eradicating this immorality, and by extension readjusting the individual prisoner to society, as lying in better classification techniques and individualised treatment.

In August 1950, Dr H. Young, the Director of the P.M.S. attended the 12th International Penal and Penitentiary Conference at the Hague. Young submitted a paper to the Conference with the title How can psychiatric science be applied in prisons with regard to the medical treatment of certain prisoners and to the classification of prisoners and individualisation of the regime? (253).

Young's question was to reverberate through the 1950s and into the 1960s. The issues of classification, treatment and training were central to the development of prison regimes during the decade. Prison doctors, psychologists and prison administrators themselves emphasised and reiterated the need for such goals, underpinned and reinforced by, as we shall see, a body of knowledge based on what they considered to be scientific research. These issues however, could not be addressed outside of the context of a prison system that was still gripped by severe crisis. Both were thus inter-related, as classification did not appear to be working there were calls for more sub-categories to be created, more subtlety to be introduced into the classificatory process. This, however, could also not be done without alleviating the problems confronting the system particularly that of overcrowding, which was to be a bane

of the prison managers throughout the 1950s and beyond. Lionel Fox, the Chair of the Prison Commissioners caught the mood of this dilemma well in a paper written for the Prison Service Journal in July 1960:

The system of classification, which is the instrument, intended to serve that end, has also, through the pressure of events, remained notably defective. If we are really to provide positive training on an individualised basis, it does not begin to be enough to divide prisoners into Stars who have not been in prison before and Ordinaries who have, even if on a very undetermined sort of basis we pick out some 'trainable Ordinaries' to go along with the Stars. We all know what varieties not only of personality but also of criminal sophistication can be covered by the word Star. In 1956 the Commissioners set up a Working Party to consider how classification might be based on a real assessment of individual personality, but the sharp increase of population that followed made it necessary to put their proposals, with many others of that hopeful interlude, into cold storage. There, on the whole, they seem likely to remain until we have the remand and observation centres forshadowed by the Act of 1948 and the Prison Rules 1949, with their specialised diagnostic staffs, to relieve the local prisons of their tasks of dealing with the unconvicted and classifying the convicted. The first of these is now being built (254).

The overcrowding to which Fox referred was a permanent feature of the prison system from the mid 1950s onwards. In 1953, the Commissioners pointed out that the continuous rise in the average daily prison population that had occurred since 1949 had been checked and that a modest reversal had happened. They saw some grounds for hope that the peak had been finally passed and "that even if no continuous decline appears the graph may at least stabilise at a level substantially below the figure of over 24,000 which was reached in the summer of 1952" (255).

This optimism was short lived. In March 1953, there was a debate

in the House of Commons on conditions in prisons. The question of overcrowding was of particular concern to MPs. Over 5,500 prisoners were sleeping three to a cell. Evidence was cited from Wandsworth in particular where the principal Medical Officer, Dr Murdoch stated that the overcrowding could "only be condemned by any doctor ... I cannot imagine any dwelling-house with one closet to 40 people. It is a disgusting thing. On the question of epidemic disease if one man gets a disease, the others will get it" (256).

In February 1954, there was another Parliamentary debate in which overcrowding was once more a focus of concern. Kenneth Thompson pointed out that the medical officers had condemned the system because of the dangers to health and that while:

he could discover no evidence that the health of the prisoners had suffered, he had himself seen the conditions and he roundly condemned them. The sanitary and washing facilities were unbelievably bad. How could we expect to get good results from our training system under such conditions? (257).

The MPs also highlighted staff problems, industrial relations and homosexuals as causes for concern. Psychiatric treatment was available according to Hugh Lucas-Tooth, the Joint Under Secretary of State at the Home Office "for those who were willing to co-operate. But the number for whom it was effective was not very great." This treatment was available from psychotherapists at certain prisons while P.M.O.s "elsewhere submitted the names of any prisoners serving substantial sentences whom they thought likely to benefit by treatment for transfer to a prison where treatment was available" (258).

Similar Parliamentary emotions were expressed in the Lords in May 1955 when once more conditions inside came under fire. For the government, Lord Mancroft, the Joint Parliamentary Under Secretary of State for Home Affairs recognized the validity of these critiques but also pointed to the positive side of prison regimes:

Many prisoners who had otherwise been written off as hopeless had been saved from a life of crime by flexible methods of corrective training. Greatly increased medical services had been set in progress since the war in local prisons directed towards rehabilitation - particularly psychological and psychiatric services, rehabilitative surgery and specialised treatment under the National Health Service both in and outside clinics and in hospitals (259).

By the end of December 1956, the prison population had climbed to 21,188. In July 1957, it was 22,340, an increase of over 1,000 in a period of six months. During the first four months of 1958 it rose to over 24,700. This was the highest figure yet recorded and by the end of the year it had reached 25,798. Altogether between mid 1956 and mid 1961 the total population of prisons and borstals rose from 20,500 to 28,500. The number of men confined three to a cell at the end of 1960 was over 7,000 (260). The immediate problems of hygiene and sanitation that this overcrowding brought was recognized both by the Commissioners, by MPs and by bodies such as the Howard League for Penal Reform whose annual report for 1954 condemned the conditions in the prisons, particularly in the local, closed prisons. The League criticised the negativity and impersonality of the prison regime and the lack of both constructive training and deterrents for those prisoners who were serving short sentences. These critiques were supported by further Parliamentary debates.

In March 1957 there was yet another debate in which Rab Butler gave his first speech as Home Secretary on the problems of the prisons, particularly prison administration, overcrowding and staffing. He also highlighted the importance of research and intimated that he had been shocked to find that the Home Office had spent only £12,000 in nine years. He felt that there was a need for:

fuller and more accurate information especially on imprisonment itself. We must use the tools which science and sociology had put into our hands to supplement the knowledge gained from experience and he therefore proposed to give research first priority (261).

In April 1958 there was a debate in the Lords on the prisons. Overcrowding once more was highlighted in what was described as an "alarming rise in the prison population" (262). Comparing prisons with hospitals, Lord Astor argued that:

prisons were like hospitals where the patients had been sent by doctors who had no specialist training, who had not had the benefits of laboratory tests on the nature of the disease, who all too often never visited the hospitals, who merely prescribed the amount of medicine the patient was to receive with little expert knowledge of its chemical contents, and whose future had little to do with the percentage of patients successfully treated. If we ran our hospitals on those lines what a chaos there would be (263).

There were again demands for greater research input. For the government, Lord Mancroft argued that "research was ..... fundamental to any consideration of the causes or treatment of crime and last year the Home Secretary .... set up a research unit within the Home Office. Increased support had also been given to projects at universities and

other institutions" (264).

In a leading article in September 1958, The Lancet argued that the prison should be transformed into a "truly 'therapeutic community'." The authors felt that too little was done with regard to rehabilitation and "too many men moulder away doing nothing useful or constructive":

The day is long past when we should be content to regard such misery and waste as a proper part of punishment: if the inmates of a Russian prison can earn reasonable wages which are paid to dependants why should not ours have an equal chance of regaining usefulness and self-respect? (265).

The journal made a similar argument in 1959 pointing out that some prisons were in fact approaching the establishment of therapeutic communities quite rapidly despite "an immense backlog of hostility between prisoners and staff and entrenched hostility." The leading article argued that:

day prisons analogous to day hospitals already exist for young offenders as "attendance centres", and the principle could easily be extended to short-sentence adults. The graded use of occupation, incentives, responsibility and half-way (pre-release) hostels are all measures of reablement common to both prison and mental-hospital systems. The future may well disclose a closer and closer identity between these two streams of therapeutic endeavour (266).

It was not only the issue of prison overcrowding that contributed to the Commissioners' unease about the prison system and its future orientation. The discipline and control of the prison population also taxed the minds of the prison managers and their medical employees. While the prison system in the 1950s did not experience

the thunder of prisoner protest that was to rock it in the following two decades nonetheless, it is equally true to say that the prisons did not progress through the 1950s with equanimity and harmony. While on the surface there often appeared to be a calm acceptance of the legitimacy of the prison regime, as in the 1940s this calmness could be shattered by individual and collective acts of concerted indiscipline. This is a history, as argued earlier, that has remained under-researched and untheorised but as I also argued earlier it is a history which can be seen to be part of that wider theoretical tradition that acknowledges the question of resistance to particular forms of domination. That resistance can be seen in the prison context to range from the refusal of individuals to accept the discipline of the regime, to volunteer for treatment programmes through to more collective forms of protest such as strikes, demonstrations and disturbances.

The Reports of the Commissioners for the 1950s reflect the tension between, on the one hand, arguing that the prison system was quieter than in the immediate post-war period, while on the other attempting to explain the acts of ill-discipline and disturbances that did take place. In the latter case, as in the 1940s, the mobilisation of psychiatric images which were then attached to the minority of prisoners labelled as recalcitrant, was an important weapon in the manager's armoury when struggle over the order and legitimacy of the system did occur.

In 1954, an unnamed doctor pointed out in the Commissioners' annual report that it had not been necessary to place any prisoners in the loose canvas restraint jacket during the year. He continued by

pointing out that "one does not see the violent psychopathic behaviour in prison today that existed 20 years ago. The pattern of the prisoner appears to have changed in this respect ..... (267).

Despite this optimism, the vision of progressive harmony could be shattered. In November 1954 there were two disturbances at Parkhurst on the Isle of Wight. One of them lasted for a week during which "a substantial proportion of the men dining in association consistently refused to eat their dinner ....." In May more serious disturbances occurred at Wandsworth when 5 prisoners attacked prison officers in a workshop and barricaded themselves into a store-room. Twenty one prison officers were injured in the incident. Altogether 10 prisoners took part in the incident in what was described as an "isolated outbreak by a handful of violent men." The Commissioners argued that such incidents were "happily rare" and the fact that they had not led to any widespread mutiny or disorder in any of the prisons was "a tribute to the firm, rational and humane control exercised by their Governors and staff" (268).

The report for 1955 continued in a similar vein, arguing that the great majority of prisoners at Parkhurst had adjusted themselves to their long sentences but there remained:

a definite though small minority of prisoners who seem quite unable to comprehend that Preventive Detention is the logical outcome of their many previous offences and that all their outbursts of indiscipline, all their threats contained in letters and petitions and all their haunting of the hospital with trivial or non-existent complaints will do nothing to shorten their time (269).



Prisoners expressed their frustrations in other ways. An unsigned letter from a M.O. in the same year discussed the fact that there had been a "considerable rise in the number of petitions" since his last tour of duty in the prison. In addition there were numerous letters to MPs as well as the not infrequent threat to "commence litigation for alleged negligence in medical or surgical treatment." From the point of view of the doctor, questioning by prisoners of his role and practice:

must breed an attitude of excessive caution in the medical officer; and he will begin to see the prisoner, not so much in the light of a patient but as a possible plaintiff in an action for negligence. I need hardly say that such an attitude does not necessarily conduce to the best medical practice, and will impair that improved relationship between medical officer and prisoner which has been so laboriously built up over the past five years (270).

The same doctor made a similar point the following year when he discussed "constant allegations of negligence and threats of litigation. Negligence is imputed almost daily to the M.O. whether verbally or in letters to friends, or Members of Parliament or in petitions" (271). In 1959, these themes recurred when sit-down strikes happened at Cardiff and Birmingham prisons. Once again the Commissioners discussed how these strikes had been well-organised "under the leadership of a small group of malcontents" (272). The Commissioners also discussed the recent instructions that had been drafted to allow for the segregation of violent or potentially violent men. Governors had been told to:

select special staff to deal with them and the attention of the medical staff has been specially directed towards their care. The object of these special instructions is simultaneously to contain

violence and to seek ways in which the causes may be removed (273).

Other prisons also had problems with discipline and control. At Dartmoor, in 1957 there were two disturbances, the second of which lasted for several days when there was a mass refusal of food. Once again, the Commissioners argued that the majority of men in the prison were acting:

at the dictation of a small group, who used this method to try to assert their authority in the prison. Suspected members of this group were dispersed to other prisons .... (274).

There were also disturbances at Camp Hill prison and at Wormwood Scrubs.

The official reports from the Prison Commissioners never addressed the complexity of such disturbances. Additionally such accounts were rarely challenged. When alternative accounts did emerge, (as we saw above with the activities of the Prison Medical Reform Council) they indicated that the roots of the conflict were more complicated than the individualised explanations propagated by prison managers and medical personnel. They also showed the state's response to be more repressive and violent than the official reports acknowledged.

In May 1959, there was serious disorder at Pentonville prison in London. The disorder centred on the execution of a prisoner named Ronald Marwood, and was repeated outside the prison when mounted police were employed to disperse a crowd of more than one thousand demonstrators. Such disorder around executions is not new but has

a long history in the social landscape of protest as individuals and groups have shown solidarity with the condemned (275). At Pentonville, the disturbance was witnessed by a team of sociologists from the London School of Economics who were conducting research in the prison. This research was to be published in 1963 under the title of Pentonville: A Sociological Study of an English Prison (276). Importantly, however, the book did not contain the details of the demonstration. This is to be found in the unpublished report of the project which the authors submitted to the Home Office.

During the demonstration, the prisoners hammered and banged on cell doors, shouted and dragged their furniture around. Forty cell locks were sabotaged. Bibles were torn and thrown from windows. Prisoners then stood at their cell windows shouting and banging their metal plates against the cell bars. Prison staff who had been off-duty were brought back from the Prison Officers' Club to supplement those on-duty:

There seems no doubt that by this stage abstract notions of 'undue force' had gone by the board, and judging from the injuries sustained by both prisoners and officers the situation degenerated into hand to hand fighting of the most uninhibited kind. One officer informant reported that one of his colleagues had come in "just for fun , but then said he felt sick. He said the P.O. told him to 'get in' and when he did he felt better, so much so that he found he was unable to stop" (277).

According to Morris et al, officers roved the prison landings in pairs with sticks, opening doors at random. For a black prisoner this had serious consequences. The prisoner had been taken by surprise shouting from his cell window. He was taken by prison officers, held upside down over the prison landing and then told

to keep quiet as he was put back in his cell:

On 12 May one of the research workers made an unannounced visit to this man's cell. He was asked to describe the events of 7 May. He said that after his door had been opened he had been taken out and hung over the landing, then thrown back in his cell. His chamber pot had then been emptied into his bed. Asked whether he had the same mattress he said "No" (his location had been changed) but that he still did have the same sheets. These were opened out and inspected, and found to be stained in a way consistent with his story. Further the prisoner's pillow case was also badly stained with urine. He said that he had made no complaint to the Visiting Justices because "This is prison" (278).

Marwood's execution was not the end of the story for those involved in the disturbances. Some of the prisoners were charged with offences against prison discipline, including assaults on prison officers. Once more, prisoners made allegations of violence, one of them had:

quite serious injuries, and had been interviewed in the punishment cells. Nevertheless, although in bandages, the senior doctor had marked his Report Sheet on 8 May 'Fit all punishment' and no mention was made of his injuries, either on his record or at the subsequent hearing of the V.C. (279).

Altogether, the prisoners lost 203 days remission and an average of 1 months privileges. On top of this, nearly all were given 9 days on No 1 diet and 9 days close confinement. Morris et al conclude that while:

there were vague plans to continue the disturbances the punishments imposed by the magistrates appear to have been sufficiently severe to deter any calculated plans for trouble, and with the passing of the execution the immediate stimulus for spontaneous demonstration had also passed (280).

Less than a year earlier, in August 1958, the report by Sir Geoffrey Vicks Q.C. had been published into allegations of ill-treatment of prisoners at Walton prison in Liverpool. Here too, Vicks found a number of the allegations to be proven including assaults by prison hospital officers:

I am satisfied that there is a prima facie case that assaults accompanied by varying degrees of violence were made upon prisoners by prison officers. Similarly that practical jokes in the worst possible taste were perpetrated, in particular squirting water through the apertures of cell doors on to the occupant within, taking him by surprise and giving him a good wetting. This was done in the hospital and the instruments used were medical syringes which were produced and demonstrated before me (281).

As I shall illustrate in Chapter 5, this was not the end of such demonstrations, nor of violence, nor of the conflict around the maintenance of order inside. For the moment, it is important to note that these escapes, the disturbances, petitions, letters and refusal of treatment all contributed to the sense of unease which pervaded the prisons in the 1950s. Once stripped of the rhetoric of Home Office discourse, departmental reports reveal a story that is much more about imposing a sense of order onto the prison system. That sense of order was in turn, shaped by the wider concerns of the managers of the system - the control of crime, the maintenance of discipline and the quest for the essence of criminal behaviour. All were key elements in the debates over and responses to crime and prisons in the 1950s. It was in this context that the medical service in prisons operated during the decade. The doctors and psychologists did not stand outside or above these concerns either as professionals working in the field or as individual members of a society whose harmonious development was flawed and gnawed at by

the seemingly insoluble question of crime and its treatment. Along with psychiatrists, psychiatric social workers and the medical profession in general they brought their own perspective to bear on the problem. It was a perspective which despite differences between the professions, was united on an ideological terrain where therapeutic intervention into the lives of individuals and families was the key to criminological success. Throughout the decade they continued to propound the view that classification, research and medical intervention were the basic elements in the search for the key. Prisons (and other institutions) were critical sites in this search which was increasingly propelled by questions of individual discipline and morality. In that sense, treatment and discipline were two sides of the same coin.

#### Medicine, Psychology and Penal Discipline.

In 1951, the Prison Commissioners identified what they saw as the proper role of the psychologist working in the prison system. That role should encompass research whose aim would be more intensive individual investigation along medical, social and psychiatric lines. The criminal's adjustment united these three lines of research. The prisoner was urged to positively accept professional investigation:

and not use it as a reason for regarding himself as a medical case or a psychiatrically abnormal person and thereby erroneously claiming exemption from the consequences of his criminal acts. Such investigations would assist not only in classification and training but in determining more closely the influences underlying delinquent conduct and enable the individual to gain insight into his difficulties and with that exper-

ience and expert assistance to acquire better adjustment (282).

This individualised approach was to harness therapy and training to discipline and regulation. As an unnamed doctor wrote in 1952, one of the aims of the doctor's work was to "make deficient men able and willing to come up to requirements." To do this, the doctor argued that medical and psychological work should be integrated with discipline and training so as to form "part of one balanced whole":

We do not conceive of medical or psychological work as being a thing apart or as even as simply running in parallel with the other work of the prison; we conceive of it as a necessary complement to discipline and training which becomes the more necessary as the quality of the population falls (283).

Two years later, another unnamed doctor was to make a similar point arguing that the more severe manifestations of behavioural misconduct were the result of head-on conflict between unstable prisoners and discipline. His prison had managed to avoid this despite the "number of potentially unstable men here. One contribution is the skill and patience of the discipline staff; the other is the pains taken by the medico-psychological staff to adjust prisoners to the requirements of discipline" (284). The Director of Medical Services also outlined the role that he saw Medical Officers playing. Once again he emphasised the fact that the doctor in prison was a member of a team and that to be successful, the Prison Medical Officer must not only recognize this but also "identify himself with the aims of the service of which he forms a part, which emphasize the welfare and rehabilitation of those committed to its charge" (285). This

identification involved considerations over and above the well-being of the prisoners in terms of their physical health. The doctors were encouraged to seek out and where possible to remedy both physical disabilities and:

*maladjustments of personality which may hinder vocational fitness or social relationships and make it more difficult for them to regain a place in law-abiding society (286).*

This inter-relationship, then, between medicine and discipline, between caring for the body and adjusting the mind, was a central plank in the development of prison medicine in the 1950s. The overlap was dialectical in that one influenced and supported the other. Often it was a question of balance:

*If, however, the Medical Officer and his staff were to confine themselves to the care of the physically sick their presence would hardly be justified, and time would often hang heavy on their hands. There is a whole range of what one must call "psychiatric" work, for want of a more accurate word, which at times is purely a medical problem, and at times may appear to be the problem of the "discipline" side; often it is a problem for both sides. If the Medical side is to be of real value it must inevitably understand and concern itself with the work and problems of the discipline staff, and neither side can afford to keep to a limited definition of their particular duty. The medical psychiatrist must, however, realise that intrusion into what appear to be purely disciplinary problems will inevitably arouse anxiety, and with anxiety, hostility to himself and his methods. It is inevitable that he will question preconceived ideas and methods, and his expertise may seem to undermine the authority of the governing staff. He must be prepared for open opposition or carefully disguised antagonism, and even be prepared for a conscious or unconscious undermining of his work and influence. He must be able to understand the antagonism when it arises and know how to deal with it, and especially he must not allow it to arouse hostility in himself and so destroy his relationships with the disciplinary staff (287).*



The psychiatric and psychological element in prison medical work continued to increase its importance throughout the 1950s. Medical personnel were vocal in their call for professional expansion, for increased facilities for personality testing and group therapy and for still further refinements in the classification of prisoners into individualised categories. In 1954, prison psychologists reached their full authorised strength for the first time since they were granted full establishment in 1950 (288). Advertisements in the medical press continued to emphasise the importance of psychology to applicants for jobs in the P.M.S. In August 1954 The Lancet carried details of the job description for P.M.O.s whose appointments were made by the Civil Service Commission in London. While the advert emphasised the care of the physically ill, the authors also underlined the fact that "the making of psychiatric assessments, the provision of medical and psychiatric reports and the giving of evidence in court when called upon are important aspects of the work." In that sense then, preference was to be given "to those who, in addition, have had post-graduate experience in psychological medicine" (289).

The extension of this psychiatric network was not without its critics. Members of Parliament, for example, raised questions about the psychiatric treatment of young women in Holloway in December 1954. These views were exceptional particularly as the government continued to press ahead with the development of psychiatric services both inside and outside the prisons, despite the doubts over how the treatment deriving from such services could be assessed. The Home Secretary, Major Gwilym Lloyd-George described this process in 1954:

The amount of time given to psychiatric treatment of prisoners by the visiting psychotherapists has increased and there have been developments of technique. Arrangements have also been developed under which psychiatrists working under regional hospital boards interview short sentence prisoners with a view to treatment being continued after release; and prison medical officers in appropriate establishments have been encouraged to give an appreciable amount of psychiatric treatment in cases not calling for more intensive treatment. The benefit derived, while not easily assessed, has been substantial (290).

In September 1958, the government once more, underlined the importance of postgraduate psychiatric experience for those wishing to join the P.M.S. The advertisement in The British Medical Journal reiterated the view that the doctor's role extended beyond the care of the physically ill to one designed to "discover and if possible remedy disabilities and maladjustments" which were felt to hinder the training of prisoners and which thus made it "more difficult for him to regain a place among law-abiding citizens" (291). In the same year, reports from Wakefield indicated the expanding role of the psychologists which had "steadily widened and become increasingly integrated with that of the administrative and training staff of the prison" (292). The initial reception report on each individual prisoner was followed up by psychologists who attended wing boards and vocational training selection boards "where they are able to interpret their initial findings within the wider training needs. Such contacts and other less formal ones with the training staff are invaluable in enabling the psychologist to report in realistic meaningful ways" (293).

Psychiatric expansion continued into the early 1960s. By 1963 the number of psychologists employed had increased to 34. They were supported by 17 psychological testers. While there were

still vacancies in both categories, the Home Office once more reiterated its support for their role in the penal system. It was a role, however, which was less concerned with writing court reports. Rather the Home Office wished psychologists to concentrate on selected prisoners and to study their behaviour in-depth. Additionally, they were to assist on staff training courses and to conduct research which the Home Office hoped would "provide the administration with operational information" (294).

Prison doctors and psychologists were therefore not only deeply involved in the debates about the nature of criminality but they were an increasing influence both in numbers and in interventions around these debates. Prisons and Borstals were the sites for these interventions, laboratories for the medical profession's case studies of the criminal mind. Throughout the decade, however, there was also another side to this story. As in the 1940s the work of the doctors and psychologists came under critical scrutiny from a range of individuals and groups who raised questions not only about the practice of prison medicine but the very philosophy on which that practice was based. If the prisons, in general, were still in a state of crisis, then the P.M.S. in particular, reflected that crisis. The years up to 1962 and the establishment of the Gwynn inquiry into prison medicine were to be turbulent and controversial.

#### The Doctor's Dilemma.

Prison medical workers were faced with a series of inter-locking

problems in the years up to 1962. These problems manifested themselves at a number of different levels. Individually and collectively they pulled medical personnel on to the centre stage in the debates about prisons and the goals of the penal system.

One problem that was to beset the service throughout the decade was understaffing. At the end of 1952 there were 9 principal M.O.s, 33 full-time M.O.s (28 men and 5 women) and 39 part-time doctors in the P.M.S. According to the Prison Commissioners there was "a large number of unfilled posts." In their annual report for the year they emphasised the seriousness of the situation:

The present position is dangerous. The service has lost experienced Medical Officers and for some time recruitment has been less than adequate. The needs of the service are expanding daily, both on account of the rise in prison and Borstal populations and by the opening of new establishments to serve a variety of purposes. Furthermore, advances in medical knowledge in general, and in psychiatry in particular, have led everyone to expect and demand more from the Medical Officer of today. Already we cannot perform, owing to shortage of staff, much of that which we consider is our duty. Further losses, without hope of retrenchment, would be disastrous and it should be emphasized here that the future requires an intake now of young, but experienced medical men, who will, in the years ahead, be able to maintain the sound traditions which have been built up (295).

A second problem was the impact of overcrowding on the health of the prisoners. This problem in terms of its impact on the daily living conditions of the prisoners and their health was to cause grave concern during the decade. From the point of view of the Commissioners, there was what they termed a "potential risk to health, consequent upon overcrowding in certain prisons" (296).

In 1953, they talked about how "hygienic problems which resulted from the necessity to continue the location of many prisoners three in a cell in local prisons did not permit any significant improvement" (297). The Commissioners argued that despite the increase in the prison population, the health of the prisoners as a collective body was not severely impaired. As they explained in 1958, "difficulties consequent upon the continuing rise in the inmate population might have been expected to result in an adverse effect on general health but in fact the annual reports from M.O.s show that health has been well maintained although some have commented upon a greater tendency to complain of trivialities" (298).

This last comment was one which was frequently expressed during the decade. The reports by the Commissioners themselves and the comments from unnamed Medical Officers often articulated the view that even when sickness rates increased, the fault lay with the individual prisoner rather than with any problem in the system. As early as 1951, the Commissioners discussed the changes in the sick treatment rate at Wakefield which rose from 6.4% in 1946 to 12.2% in 1951. The Principal Medical Officer at the prison linked the rise to "a decline in morale consequent upon the departure to open prisons of the better type of prisoner who rarely complains sick without due reason" (299). In 1954, similar views were expressed. The Commissioners talked of prisoners having immature personalities, exhibiting hysterical traits, who exaggerated symptoms, who were sometimes propelled by ulterior motives or who in their situation tended to lose a sense of perspective. These factors, they concluded, "have to be taken into consideration and may increase the complexities of the task" (300). One unnamed doctor, also pointed to what he

saw as the problems in giving treatment to prisoners:

The more defiant types received in later years seek medical treatment much more frequently because of their greater immaturity of personality which impels them to seek some kind of substitute maternal care and protection when they are in any difficulty. The sick rate in prisons is not necessarily, or even mainly, an index of physical health; it is more an index of morale and the management of morale is as important as the giving of ordinary medical treatment (301).

This line of argument continued into the early 1960s. In 1961, the Director of Medical Services discussed the discomfort brought about by overcrowding which in his view had not in itself resulted in increased ill-health. The number of "trivial sick complaints" remained high but this "may be no more than a reflection of an attitude present in the outside world. However, this must be qualified by the observation that trivial sickness complaints tend to decrease when morale is high" (302). Others were less sanguine in their comments about the health care of prisoners and the impact that conditions had on their physical and mental welfare. In 1954, the annual report of the Howard League suggested that in order to cope with the increased work-load that the P.M.S. was facing and "to secure some uniformity of procedure and a broadening of experience a closer relation between the Prison Medical Service and the National Health Service should be encouraged" (303).

In the House of Commons in April of the same year Frank Allaun raised the question of medical treatment at Strangeways prison, Manchester. Allaun was concerned about the fact that prisoners with tuberculosis and confined to bed for long periods were being kept in ordinary prison cells. In addition, while the prison held

1,100 prisoners, there were only four one-bed rooms for men who had to be isolated either for physical or mental reasons. Allaun went on:

Would the Minister agree that, whatever a man's prison sentence, his health should not be damaged by it? Will the minister therefore ensure that sufficient hospital beds are made available at Strangeways, for tuberculosis patients and others with serious illness, particularly since, as I saw last week, it is extremely difficult for prison officers to carry sick prisoners into the four single bedrooms, two of them padded cells, because of the narrowness of these archaic corridors (304).

From the government's point of view, the hospital was regarded as "admittedly inadequate." The solution to the problem lay in the building of a new hospital which would involve "substantial reconstruction of other parts of the prison." This would be done when funds became available (305).

The following month questions were again raised in the Commons about the state of prison medicine. Victor Yates expressed concern about the medical treatment and the welfare arrangements for prisoners on their discharge. Yates argued that from his personal observations in visiting Parkhurst, the arrangements for prisoners suffering from tuberculosis were "totally inadequate." The Under Secretary of State at the Home Office, Sir Hugh Lucas-Tooth defended the P.M.S. arguing that a prisoner who was dissatisfied could ask to see the Director of the P.M.S., petition the Secretary of State or write to an MP:

He had no wish to be complacent; he knew that there was a deficiency of medical officers and the present overcrowding in prisons was a very grave menace. But last year there were no serious outbreaks of infectious

disease, and prisoners generally were in better health on leaving prison than when they came in (306).

The qualifications of the doctors with regard to the psychological treatment of prisoners was also a cause for concern. In March 1957, Dr. Barnett Stross raised this issue in Parliament by asking how many of the full-time doctors employed in the P.M.S. held the Diploma in Psychological Medicine. Of the 49 full-timers, 6 held the Diploma. Following this, Stross asked:

would it not be unreasonable to ask that when any improvements are made in the service a special point should be made of ensuring that as many medical men as possible who serve full-time in the prisons should have the diploma and that outsiders coming in to assist should also where possible, be skilled in psychological medicine?(307).

The doctors themselves were unhappy about their own status and position in the prisons. This was debated both in the national and in the medical press (308). In April 1959, a correspondent wrote to The Lancet outlining his dissatisfaction and anxiety over the kind of work he was asked to do. Signing the letter "White Slave" he argued that P.M.O.s tended to become a "jack of all trades and a master of none". They doubled the role of specialist psychiatrist with the general treatment of illness "and as a side-line, [are] expected to approve or condemn food, as well as other public health duties" (309). The author complained that prison doctors feared that as more specialist work became available it was likely to be done by specialists from outside the P.M.S. on a sessional or even a full-time basis. He concluded:



before the contribution psychiatry had to offer be assessed it should be practised by duly qualified persons in an adequate setting. At present the prison medical officer is being asked to undertake psychiatric diagnosis and assessment under very nearly impossible conditions: assessment being of necessity based on short interviews punctured by interruption, in many cases no social history and no corroboration of the prisoner's story, and a confusion of roles in which the "psychiatrist prison medical officer" is supposed to function (311).

He also proposed that the "small and inadequate" P.M.S. should be integrated with the NHS. For him full integration:

would do away to a large extent with the inflammatory bandying of words and concepts regarding "fishes in small ponds" and the particular alphabet after one's name; it would all be irrelevant and the law of natural selection would maintain. We would all struggle in the same "big pond", the better man would tend to win, and psychiatry, the Prison Service and the prisoner would benefit (312).

The question of integration amongst others was taken up in a leading article in The Lancet in October 1961. The article identified a number of problems in this "corner of medical practice - one might almost say a backwater - that receives little attention" (313). The question of isolation, the "vicious circle of understaffing," the lack of formal training in psychiatry, psychology and sociology, and the terms and conditions of service were all identified as contributory factors in the problems that the P.M.S. faced. In addition:

As with the military services (from which some prison doctors came) the organization is inevitably somewhat dictatorial. A man is "posted" from place to place, and prison accommodation is not always in a district likely to prove acceptable to the doctor's wife or helpful to his children's education. Promotion by seniority is very slow and salaries are rather lower

than NHS equivalents, despite a rise last January (314).

The article concluded that amalgamation of the P.M.S. with the NHS would "undoubtedly solve many problems" that a "careful study of the situation is overdue" and that an inter-departmental committee should be set up to review the position (315).

Once again, the article provoked strong emotions in the letter columns. Richard Nunn, the General Secretary of the Institute of Professional Civil Servants defended the P.M.S. and asserted that the considerable developments that had happened in recent years meant that prisoners were "now afforded treatment which compares favourably with National Health Service standards, despite the overriding necessity for security" (316). He concluded that there was no advantage to be gained in amalgamation with the NHS. Nunn's letter was not the only response to the article. Other writers raised a number of further issues including the involvement of the doctors in the use of padded cells and strait-jackets in the prisons and their role in capital punishment and the execution of individuals sentenced to death. According to Frank Byram this meant that:

many, perhaps most doctors fight shy of a Service in which their patients may include a man or woman under sentence of death. The doctor may even be required to use his skill so as to ensure that his patient shall survive until execution (317).

Two prison doctors responded to the question of the strait-jackets and their role in supporting them. The doctors, once more, raised the question of the aggressive, psychopathic offender and his treatment in the overcrowded local prison. They felt that it might be

possible, perhaps even desirable to abolish them. This could only be done, however, if some modified form of restraint was retained for use as a temporary measure "with violent prisoners until the drug of choice has begun to take effect." The doctors were making reference to the fact that they were up-to-date with the newer and more effective methods of diminishing violence, in this case drugs. They felt that those who made comments were unaware of these methods and were "wholly ignorant of the yearly expenditure on the various anti-depressant and tranquillising drugs that are prescribed by these doctors and therefore included as an item in the annual account sheet" (318).

Finally, the status of the doctors with regard to psychiatric evidence was also highlighted. One prison M.O. argued that organizationally the Service had been undermined by the Prison Commissioners who had prevented serving M.O.s from obtaining the Diploma of Psychological Medicine and had denied him and others "the hope of official recognition as any kind of specialist":

specialist status seems to be deliberately withheld to prevent our acquiring a higher "market value", and this is one reason why so many ambitious young medical officers resign while they are young enough to win their spurs elsewhere. One result is that P.M.O.s are mainly rather old or young and inexperienced. Even a single retirement causes a frantic reshuffle, and a number of my friends must retire in the next few years (319).

While he still remained passionately loyal to the Service "some drastic action is needed to prevent the extinction of the P.M.S." (320).

Other voices were also heard objecting to the medical treatment of the confined. As in the 1920s and the 1940s there were strong criticisms raised by ex-prisoners, particularly by those who had been involved in the demonstrations around the Campaign For Nuclear Disarmament in the late 1950s and early 1960s. Members of the Committee of 100 had been imprisoned for peacefully protesting against nuclear weapons. When released they published a pamphlet under the auspices of the Prison Reform Council, the successor to the Prison Medical Reform Council of the 1940s. The pamphlet, Inside Story, was based on the experiences of 30 prisoners at 12 prisons. Once again, the authors castigated medical provision inside for its callousness, its 'don't care' attitude towards the prisoners, the deprivation of essential medication to asthmatics that had been brought in with the prisoner and the fact that physically ill prisoners were kept standing waiting for medical treatment in draughty corridors outside the M.O.'s office. Finally, pregnant women were only allowed one egg a week.

Additionally, the context in which medicine was practised was also severely criticised including the use of confidential information taken from letters by prison officers to taunt prisoners, floors being scrubbed with nail-brushes, civil prisoners being denied the right to wear their own clothes and having to work and exercise in the rain without protective clothing. In its editorial comment, The Lancet concluded:

There seems no reason to doubt the honesty of these reports, despite immediate denial by the Home Office ..... All this accords with the revelations related to the use of strait-jackets in prisons and we are reinforced in our view that the Prison Medical Service is in urgent need of a thorough overhaul (321).

Once again the doctors defended their position. In a letter to The Lancet in March 1963, four M.O.s from Wandsworth, (a prison which had not been highlighted in Inside Story), accused the journal of being biased in its views of the P.M.S. although they did concede that "one of the persistent problems that the Prison Medical Service has had to face has been the difficulty in finding suitable recruits for what must always seem at least in some respects, an unattractive career for the majority of doctors" (322). The pamphlet was also the subject of Parliamentary debate. In April 1963, Lord Stonham initiated a debate in the Lords concerning what to him appeared to be a discrepancy between penal theory and prison practice. In particular, the conditions inside, the use of strait-jackets and the work of the P.M.S. were central elements in Stonham's critique. He felt that the Service could not be reorganized but should be abolished, not only because it was expensive but also because it was:

not the business of the Home Office to run a medical service at all. It would be a great step forward if sick prisoners could be treated as patients within the Health Service by doctors and consultants who, because they remained in contact with the outside world, could retain a proper sense of human values (323)

In defending the pamphlet, one of the writers, Oonagh Lahr, also called attention to the P.M.S. and suggested two further reasons why the service called for particular attention:

Firstly, a prisoner's life is unhealthy in almost every way - as regards exercise, food, hygiene, sanitation, clothing, heating, sexual problems, enforced self centredness and nervous strain. Secondly, there is no class of human being more completely in the power of those in charge of them except the insane and children. If someone

who has personal experience of deficiencies in the medical service brings forward truthful testimony about it, I do not think such testimony can be dismissed by responsible persons without impartial investigation (324).

Other aspects of the doctor's role were also severely criticised.

The psychiatric qualifications of the doctors came in for particular attention. Leo Abse raised the issue of P.M.O.s regularly submitting reports on the sanity of accused persons to the courts without a recognized psychiatric diploma. He also raised questions about the fact that individuals charged with murder and remanded in custody, "were being compelled to submit to psychiatric examinations by prison medical officers and the facts so obtained were supplied to the Director of Public Prosecutions" (325). This question had been discussed as early as May 1954 when The Lancet raised serious objections to the doctors in the remand prisons submitting reports on accused persons. In a leading article, the journal argued:

.... we trust that some alternative will eventually be found to the present system whereby examination of the prisoner is normally limited to the facilities (or lack of them) at an ordinary remand prison. Moreover anyone familiar with the full reports of recent trials on capital charges will be aware that the prosecution often benefits from the fact that the prison doctor has had the accused under continuous observation during the period of remand, whereas outside specialists called for the defence must base their findings on short interviews (326).

In February 1961, Abse once again attacked the practice. In his view, nearly all of the P.M.O.s "lamentably, lacked any psychiatric diploma." Despite this, after interrogating a prisoner and submitting a report to the Director of Public Prosecutions which indicated that the prisoner was not unbalanced, the P.M.O. could contribute

to the accused being convicted of murder rather than manslaughter.

He pointed out that:

if the existing malpractices continued, we were in danger of verdicts of murder being given as a consequence of a clandestine investigation conducted in a prison cell between a doctor and a patient he had compulsorily acquired, and not as a result of evidence which would otherwise have been placed before an open court. The position now being adopted by the Prison Commissioners required their medical employees to be flagrantly in breach of the Hippocratic oath (327).

Abse was supported by Allen Bartholomew who in a letter to the BMJ argued that "many medical officers reporting on the mental state of prisoners not only lack a diploma but also lack (at least initially) experience." Bartholomew felt that as it took only two years working in an approved hospital to sit for the D.P.M., many of the M.O.s in the prisons must either be failed D.P.M.s or have worked in the psychiatric field for less than two years. He concluded that the way forward was to have fully trained personnel who were knowledgeable in psychiatry, law and penology but who were not also asked to be a general practitioner, a public health expert and in some cases a nurse:

Mr Abse is to be congratulated on airing this topic in Parliament. There would seem to be a strong case for the integration of the Prison Medical Service with the National Health Service (328).

In November 1962, Leo Abse, once more asked questions in the House of Commons both about the inadequate numbers and sparse psychiatric qualifications of prison doctors. He also expressed his concern about the use of strait-jackets by prison doctors. In 1961, 86

men had been put in strait-jackets, one of whom had remained in it for nearly 48 hours. In February 1963, he reiterated the point. On this occasion he used an adjournment debate to raise questions about strait-jackets inside. He pointed out that in 1961, strait-jackets had been used on more than 100 occasions on men and women in prisons and borstals. He felt that they were being used for "incredibly long periods of time." Additionally he pointed to the gap between "the practice and judgement of those with psychiatric experience and qualifications inside the National Health Service and doctors in the Prison Medical Service (329). Again he called for an overhaul of the Service and an "intelligent ebb and flow" between doctors in the P.M.S. and the N.H.S.

In replying for the government Charles Fletcher-Cooke, the Joint Under Secretary of State at the Home Office, indicated how he saw the connection between strait-jackets, the prison doctors and other forms of control, particularly drugs. Cooke pointed out that in the majority of prisons, doctors who were called to treat a prisoner who was being violent as a result of mental disturbance did not necessarily have the same experience of dealing with violence by sedation as the staff of mental hospitals. In his view:

Some immediate action was required to prevent the prisoner from injuring himself or others or creating a disturbance which in a prison could have serious consequences. Every effort was made to quieten the prisoner without recourse to mechanical restraints, including the use of sedation, if the prisoner could be induced to accept it (330).

The use of drugs brought its own problems for the doctors: the question of broken needles and the issue of the prisoner's consent



being two of the main ones. If consent was not forthcoming then the doctor left him/herself open to an action for assault. It was Cooke concluded "much more serious to inject someone with a drug against his consent than to put him in a restraint jacket" (331).

The easy elision between mental disturbance and prisoners resisting the regime had been highlighted two years earlier by the Home Secretary, R.A. Butler. Replying to a Parliamentary question, Butler pointed out that strait-jackets might be used in prisons when it was necessary to "restrain a prisoner suffering from mental disturbance to avoid his injuring himself or others, or damaging property or creating a disturbance. It might only be used on medical grounds on the written order of the prison medical officer" (332). Tranquillizing drugs, he added, might be used as an alternative in appropriate cases.

The overlap between treatment, discipline and control, has, as I shall illustrate in Chapter 4, a long history in relation to the Prison Medical Service. It became particularly relevant in the mid 1950s with the development of psychotropic drugs and their role in dealing with disturbed individuals. The prison doctors themselves were not unaware of the close connection between treatment and discipline, care and control. Dr H.K. Snell, the head of the P.M.S., (who was later to sit on the Gwynn inquiry into the Service in 1962) outlined this relationship in an article in the Howard Journal in 1959. He argued that the individual prisoner must learn to accept 'his' responsibilities and that doctors could not be used as a shield:

Discipline is essential, not only for the proper administration of the prison and indeed, for the general well-being of those detained therein, but also to provide a realistic background against which general training and character development can be undertaken. This discipline, plus the individual help which the prisoner must feel is available to him, not only from medical and psychological staff but also from his assistant governor and officers, will compare with the discipline of a well-managed home in which there is a sense of security plus a knowledge of disinterested but genuine help (333).

Outside commentators were less sanguine about this relationship and saw the dangers that the increased involvement of doctors in a range of social problems could bring. In the Winchester Address to the British Medical Association in January 1963, Barbara Wootton voiced her disquiet over the increasing tendency of doctors and psychiatrists to be involved in every broadcast and discussion on moral issues:

To-day personal problems, moral problems, marital problems, problems of deviant behaviour, are constantly brought to the doctor's consulting-room while social workers, with their "case-work" and their "diagnostic" and "therapeutic" techniques, adopt medical poses and express themselves in medical language (334).

Wootton was particularly concerned to analyse the role of doctors who undertook the psychiatric treatment of offenders. She argued that such doctors were unlike other doctors or psychiatrists and did not simply function as attendants on the mental and physical illnesses of confined individuals. More fundamentally:

He has in effect become an agent of the State - part of the machinery of law-enforcement. Such a change would perhaps have shocked Hippocrates. Certainly it is too profound a revolution to be

allowed to slip by unnoticed. If the profession is to assume what are essentially corrective rather than therapeutic functions, it is surely important that this should be done openly, and not by the specious pretence that the two categories are indistinguishable (335).

For Wootton, the passing of the 1959 Mental Health Act illustrated this process perfectly. Decisions which involved important social and moral elements were being made by medical (usually) men alone. They had responsibility for the diagnosis and where necessary, the compulsory detention of those classified as mentally disordered. The "alarmingly wide powers" contained in Part IV of the Act gave them considerable discretion in the interpretation of psychopathic disorder. It was:

difficult to think of any form of objectionable behaviour which this formula would not cover. The idle, the man who drifts lightheartedly from job to job, the unfaithful spouse, the unmarried mother, not to mention the reckless youth on a motor-bike, would all seem to be potential candidates (336).

Such definitions allowed The Times to discuss the provision of two specialised centres for the treatment of psychopaths not motivated to seek treatment but who exhibited such antisocial tendencies as alcoholism, drug addiction, persistent forgery, promiscuity and homosexuality (337).

Other commentators have also argued that the 1959 Act was an important moment in the extension of the medical profession's autonomy and legitimacy. As Andy Treacher and Geoff Baruch have

pointed out, the 1957 Royal Commission which preceded the passing of the 1959 Act was "dominated by the medical profession." In that sense, the Commission's report and the 1959 Act which translated its recommendations into law represented "the final victory of the medical profession in securing its claims to prime responsibility for the mentally disordered." For Treacher and Baruch:

This victory occurred in a period when the state increasingly intervened to regulate and control more and more aspects of everyday living. The extension of the sick role to encompass many forms of deviancy which reflect the basic conflicts in a class society more clearly and openly than issues relating to general health or illness, has obvious advantages to ruling groups within that society. The psychiatric profession, operating from the standpoint of self interest has been a willing tool in this process of mystification, but there is a very real sense in which the profession creates and perpetuates the very problems which it claims to be able to solve (338).

This argument had relevance for the impact that the Act had in the prisons. Both The Lancet and the British Medical Journal commented on the situation of those remanded for mental observation both before and after the Act came into force:

During the first ten months of 1960, before the Mental Health Act came into force, 5% of those remanded for mental observation were found to be insane, while in the last two months of that year, under the terms of the new Act, the proportion was 10.4%. This suggests that the increase is due mainly to the new provisions and the way they are interpreted (339).

The Lancet made a similar comment in its review of the Commissioners' Report for 1959:

.... the number found insane on remand jumped to almost double despite a decline in the number remanded for mental observation and report. It is hard to explain these trends; perhaps the new outlook inherent in the Mental Health Act of 1959 may have permeated the prison medical services more quickly than it has influenced the judicial authorities (340).

This issue was discussed in the context of the more general debate about the role and efficacy of the prisons in dealing with crime. Again it was felt that the prisons were failing in their role to both deter and rehabilitate the individual criminal. This itself was connected to a more general bewilderment about the causes of crime, particularly in an age of apparent post-war prosperity. Thus, in yet another Parliamentary debate in April 1959, both Viscount Templewood and Lord Moynihan argued that despite the rise in material wealth and the expenditure on the welfare state, crime was still rising. Moynihan was explicit in linking welfare and crime, for while the welfare state was excellent in theory:

was it not ... in practice turning out to be an ill-timed attempt to alleviate fears and increase the happiness of the masses? Because of the speed with which it had been presented it was encouraging people to work less for more money and without any proper idea how to use their spare time (341).

While this was the case regarding welfare, he believed that spending on prison building had "lagged behind every other country." There were calls for further research with particular attention being focussed on the foundation of the chair and readership in criminology at Cambridge. Additionally it was felt that psychiatry and medicine could make a greater contribution to the problem. As Lord Stonham argued:

We should remove from our ordinary prisons the human derelicts, geriatrics and misfits who were enemies not of society but of themselves. They cluttered up the prisons and impeded officers in the task of rehabilitating those who had committed serious crimes. On conviction they should be classified by doctors and probation officers and if necessary they should be detained in a colony under ordinary discipline and obliged so far as possible to earn their keep (342).

In replying for the government, Lord Chesam reiterated the view that the causes of crime could not simply be put down to bad housing, poverty or inadequate educational or social services. The causes were more deeply rooted than this extending "beyond the reach of Government action. To cure crime would require a gigantic operation by both central and local government, by the churches, by the voluntary societies and by an increase in the moral responsibility of the people as individuals" (343).

By 1962, The Lancet felt that financially the prisons were still "poorly endowed" and that while the population of the mental hospitals was mostly decreasing the prison population was steadily increasing. With a population "of over 30,000, the increase has been of 50% since 1955 and of no less than 300% since 1940; and over 8,000 men sleep three to a cell." The journal also described the group counselling techniques which operated in the prisons which were designed to "help correct, in some degree, the distorted view which many inmates have of themselves and of society and which is often responsible for the behaviour which has brought them into conflict with the law." This technique The Lancet felt was working out into a "kind of superficial and authoritarian psychotherapy rather different from its more psychodynamic origins in the USA" (344).

The annual reports from the Prison Commissioners also highlighted the problems with group counselling as prisoners increasingly refused to participate. As one unnamed doctor wrote in the report for 1961 "there has been a noticeable decline in the number of volunteers and most groups have had to be made up by persuasion" (345). Similar emotions were expressed in the 1962 report. One of the unnamed writers pointed to the fact that some 75% of all receptions:

will be influenced by group counselling in varying degrees. On the negative side, and because the groups are completely voluntary, those who might benefit from, and need group counsel most are able to opt out right from the start. Thus the worst element with its anti-social, and vicious disruptive influences remains unaffected and continues to exert pressure on the rest of the inmates, thereby poisoning the attempt to further a constructive staff/inmate relationship (346).

The application of these techniques, and the problems surrounding them, were worked out in the context of the increasing concern for security that began to intensify and ripple through the Prison Service in the early 1960s. In the summer of 1961 a security wing was established at Durham prison for prisoners who needed special security conditions. Up to 31st March 1962, 52 men had been transferred to the wing. In the same year other long-term prisoners were being transferred to two special units at Hull and Parkhurst. In this atmosphere, the Prison Commissioners urged that when groups met for counselling sessions, the staff member involved had complete discretion to use the information obtained "either in the interests of security and good order of the institution or in the interests of a particular individual" (347). The Commissioners were quite clear where the thrust of the sessions lay:

The essence of the technique being to give inmates an opportunity to discuss frankly their difficulties and problems, it is to be expected that criticisms of the prison and borstal system generally, of the rules and of the people who administer them, may (not necessarily will) feature prominently among the topics in group counselling sessions. But since the sessions are not a channel for remedying grievances, and discussion of the system's and the staff's shortcomings will not, therefore, alter anything, groups may be expected to forsake this topic for the more fruitful one of what group members themselves should do to solve their problems (348).

For the women at Holloway, group counselling was also an important part of their lives. Its scope was widened in 1961 to take in local recidivist women as well as those in the regional training prison. It was also accompanied by a "vigorous staff training scheme" within the prison so that as many officers as possible could act as counsellors. According to the Commissioners, such counselling had "produced a more relaxed atmosphere in the wing concerned and a more sympathetic attitude between the staff and women" (349).

The prisons were also beset by a number of disturbances and strikes during the early part of 1961. In their annual report for the year, the Commissioners discussed the cases of indiscipline that had occurred. Prisoners had used the tactic of "standstill" when they were ordered to proceed to work after their exercise period. The Commissioners were clear where the blame lay:

The first of these received considerable publicity in the national press; and a wave of imitative hysteria affected other prisons until it came to be realised that group disobedience has to be paid for individually. Prompt and firm measures were taken by Governors in dealing with such outbreaks and the epidemic died out. Although these demonstrations were described by some of the participants as protests against overcrowding,



food or earnings, they were, in fact, stimulated in each case by a small number of aggressive men as a deliberate challenge to authority, in which most of those taking part became unwittingly involved (350).

Medical power was mobilised to deal with the most troublesome prisoners, especially, the persistently violent. The detached wing which had been prepared at one prison to take such prisoners out of circulation and which opened in May 1961 provided the means "with the help of specially trained staff of attempting to find out why these men are violent and if there is any way in which we can modify their violent tendencies" (351). It had a specially selected staff of hospital and discipline officers under a Hospital Principal Officer and the general oversight of a Medical Officer who was also responsible for case-work.

Again in December 1962, there was trouble at Dartmoor where 11 prison officers were injured. The Commissioners blamed "one or two aggressive men as part of an unremitting campaign against authority" (352).

All of these issues - the general state of the prisons, the lack of research on and rehabilitation in the criminal, the apparent inadequacy of the P.M.O.s' qualifications, the involvement of doctors in the control of prisoners - brought the question of what should be done about the Prison Medical Service to a head. In November 1962, the Home Secretary Henry Brooke, announced in consultation with the Ministry of Health the establishment of an inquiry into the structure and function of the P.M.S. and its relationship to the NHS. The inquiry was to be conducted by officials from the Home Office and the Ministry of Health with

the assistance of Professor Dennis Hill of the Middlesex Hospital Medical School and Dr Peter Scott of Maudsley Hospital. In welcoming the statement, the P.M.S.'s most persistent critic Leo Abse, said that he hoped that full attention would be given by the Committee "to the manner in which the P.M.S. was at the moment so totally insulated from all modern trends in the Health Service, so that they might hope to have a service in prisons which would help to prevent crime" (353). It was a hope that was soon to be disappointed. By February 1963, he was already talking about the inquiry as a "clandestine interdepartmental study" (354). For Abse, and the other critics, there was to be no metamorphosis in the work of the P.M.S.

#### The Politics of Gwynn.

Working parties, committees of inquiry, judicial inquiries and Royal Commissions, have perennially played a part in the repertoire of responses commanded by the British state when an institution is in crisis. As Philip Corrigan and Derek Sayer have argued, such inquiries and commissions have a long history within Britain and serve an important legitimating function with regard to political practice. The set agenda, controlled membership, the definite form of inquiry, the relationship between gathered evidence and final facts which form the basis for reports and final recommendations are all part of a process in which fundamental alternatives to the prevailing orthodoxy are closed off and marginalised. As they note, such inquiries are part of the more general establishment of state practices in which particular definitions of reality are

both forged and propagated. These definitions utilise:

an immensely powerful language, alternative representations appearing fragmentary and insecure in the face of this massively authoritative organization of what is to count as reality. This system of power is inseparably also a system of knowledge, both in terms of quantity ..... and quality. Recall the long, long history of surveys, commissions, inquiries, inspections, the establishment of authorised facts, in England, from Domesday to the Blue Books (355).

Allied to this is the individual membership of such committees, "social individuals in historically constructed relations" whose own background experiences and ideological preferences are crucial determinants in the construction, direction and final form reports and inquiries take (356). The history, work and conclusions of the Gwynn inquiry was no exception to the thesis outlined above and provides a good example of state management at its best in dealing with an institution in crisis.

First, there were no women on the working party team which had eight members and a secretary. Four of the eight were members of the medical profession and included H.K. Snell, then the current Director of the Prison Medical Service. A second member, Professor J.D.N. Hill had as I have indicated earlier been involved in the debates about and research on the causes of crime since the early 1950s. He had published research on electroencephalography and had contributed to a number of publications which were forensically orientated in both their theories of, and policy prescriptions about criminality. He was also a member of the Eugenics Society (357). Dr P. Scott, the other external advisor was himself closely associated with the P.M.S. both as a visiting psychotherapist at Brixton

and as a psychiatric advisor in Grendon Underwood prison, a post to which he was appointed in 1963. He had also published work in the area of crime and deviance including "Homosexuality, with Special Reference to Classifications", "Treatment of Psychopaths" and "Psychopathic Personalities" (358).

Among those who gave both written and oral evidence was T.C.N. Gibbens from the Institute of Psychiatry who as I have indicated above was heavily involved through the 1950s in attempting to construct forensically based prediction tests to identify those who had propensities towards future criminality. In giving evidence, Gibbens's work was not finished. The report, containing 11 pages of text, was received by the Home Secretary in February and published in April 1964, seventeen months after the working party was established. On April 23rd, Brooke told the House of Commons that he accepted the recommendations made in principle "subject to consultation with the interests concerned." In order to do this, he had set up a further committee on which:

officials of the Home Office and the Ministry of Health have the assistance of Dr T.C.N. Gibbens of the Institute of Psychiatry and of Dr P. Scott of the Maudsley Hospital in dealing with the implementation of these recommendations (359).

Altogether there were 15 recommendations which were gleaned from the report's 35 paragraphs. The working party rejected the idea of full integration into the NHS despite evidence from the Royal College of Physicians, the Royal Medico-Psychological Association, the National Association for Mental Health and the Institute of Psychiatry which all favoured complete integration. The BMA and

the doctors' own union, the Institution of Professional Civil Servants did not. To cope with this issue the working party recommended the continuation of a dual system with more NHS appointments in the prisons but the preservation of the full-time doctors in the P.M.S. who would remain responsible for organizing the medical services in prisons. In addition, it recommended a system of joint appointments in which the Home Secretary and hospital boards would together appoint psychiatrists to work part-time in the P.M.S., the remainder of their work being in hospitals or clinics outside of the forensic field. The British Medical Journal concluded that the "increased experience that joint appointments would allow the holders of them to acquire should prevent forensic psychiatrists from becoming too cut off in their speciality within a speciality" (360). The Lancet was more critical in its appraisal for while it argued that the report was "remarkable for its clear examination of the issues," it raised a number of other concerns which were to prove prophetic in the ensuing years:

..... whether the proposed remedies will sufficiently stimulate recruiting may be doubted: indeed, the working party expects considerable delay before enough doctors are trained. It recognises also the possibility of friction in a dual-control system unless all concerned make an effort to work together. Furthermore the report hardly gives due weight to the need in prisons for full-time doctors who are deeply involved in the life of the prison, its climate, and its morale. Unfortunately little is said about the work being done by the present service, and the extraordinary difficulties of meeting the demands of a distressed, exasperated, and commonly abnormal population (361).

There was not to be another review of the work of the P.M.S. until the May Inquiry was established in the winter of 1978. In the fourteen years between Gwynn and May other issues were to impose

themselves into the lives of the managers of the prison system and their medical employees. The opportunity that Gwynn missed to address the questions confronting the P.M.S. was to prove costly. As Chapter 5 indicates the doctors and their subordinates far from being allowed to develop their occupational roles harmoniously as Gwynn had hoped were to become embroiled in even greater controversy in the following two decades as prisoners' rights organizations focussed their attention on the role of the P.M.S. in the struggle to maintain order in an increasingly brittle and fragile prison world. The search-light of scrutiny that these organizations operated, once again raised serious questions about the medical treatment of the confined, the use of drugs to control prisoners and most serious of all, the issue of deaths in custody which had like the prison itself hitherto remained covered by a blanket of secrecy. That blanket was to be torn throughout the 1960s and 1970s. Through the gaps and into focus came a medical world which was not only caught up in but was as ever willing to respond to the crisis that gripped the prison system in those two decades. These responses were forged on the anvil of that crisis. Increasingly however, it was prisoners and their supporters who kindled the fires on which the anvil stood.

Chapter 4

Medicine, Regulation and Control in the Penal System.

If we accept uncritically ..... bourgeois presuppositions, we will look at doctors and patients as individual actors, behaving or misbehaving, rather than as members of classes, sometimes in conflict with one another, sometimes forming their identities in their relations with one another. We will also miss the fact that medical theories incorporate broader historical aspects such as class behaviour and that medical practitioners behave in accordance with them, not as individuals (1).

..... not only is disease related causally to the social and economic situation of the members of a given population, but the health care received also reflects the structure of a society, particularly its stratification and class divisions. Rank has its privileges in illness as in health. From antiquity to the present, the social class of the patient has in various ways affected the medical transactions related to his illness (2).

Before considering the genesis and consolidation of the P.M.S. it is necessary, once more, to introduce a theoretical dimension to the discussion. Again, a critical evaluation of the work of Michel Foucault provides the necessary conceptual tools for this discussion. In Chapter 1 I indicated the importance of his work around the themes of power, knowledge, discipline and classification and how a critical reading of these concepts was the key to unlocking the door of prison medicine. His book Discipline and Punish was a central text for this analysis. In a number of other books, most notably, The Birth of the Clinic and Madness and Civilisation Foucault focusses on the specific question of medicine and its emergence at the end of the eighteenth century. Again this work is both provocative and stimulating. What is important about his analysis is not simply that it allows us to see the historical abuses that have come with power and domination in Western capitalist



democracies (although given the narrow historical parameters within which the contemporary media 'explain' events that cannot be disregarded) but more fundamentally, how the emergence of medical discourse was part of a disciplinary project orientated to:

creating a model individual, conducting his life according to the precepts of health, and creating a medicalized society in order to bring the conditions of life and conduct in line with requirements of health (3).

What he terms the "medicine of social spaces" emerged at the end of the eighteenth century and covered not only the health of the individual but also regulations governing housing, food and even child-rearing. In Foucault's view, they were measures to extend "control over minutiae of the conditions of life and conduct" (4). Within this discourse, the medical profession was pivotal, building a body of knowledge on surveys, reports and case-histories. It was, in his view, a "medico-administrative" knowledge. In this context:

The doctor wins a footing within the different instances of social power ..... The doctor becomes the great advisor and expert, if not in the art of governing, at least in the art of observing, correcting and improving the social "body" and maintaining it in a permanent state of health. And it is the doctor's function as hygienist, rather than his prestige as a therapist, that assures him this politically privileged position in the eighteenth century, prior to his accumulation of economic and social privileges in the nineteenth century (5).

There are two further dimensions to this process which are also important for this study. First, the process he calls normalisa-

tion allows us to see how the advice and expertise of the doctor was geared to reintegrating the institutionalised back to the norm. Domination through observation objectified the prisoner, and "effectively optimized the capabilities of the body, simultaneously enhancing its economic utility whilst ensuring its political docility." As Barry Smart points out:

Within institutions, organizations, and associations and on the part of individuals themselves, judgements, assessments, and diagnoses began to be made of normality and abnormality and of the appropriate procedures to achieve a rehabilitation or a restoration of and to the norm. Intrinsic to the growth of a "normalizing" power were particular relations of knowledge, notably the judgement and examination, which effected an objectification of human behaviour and in addition provided a necessary condition for the emergence of the human sciences (6).

Second, the use of the examination, probing, testing, studying the body and the mind was also a central element in the development of power relationships. As Foucault argued:

... the examination is at the center of the procedures that constitute the individual as effect and object of power, as effect and object of knowledge. It is the examination which, by combining hierarchical surveillance and normalizing judgement, assures the great disciplinary functions of distribution and classification (7).

It was within the prison - "that darkest region in the apparatus of justice" - that these processes became manifest. It was here, behind the walls, that medicine, psychology and criminology took their place, correcting, disciplining, normalising. It was a site:

where the power to punish, which no longer dares to manifest itself openly, silently organizes a field of objectivity in which punishment will be able to function openly as treatment and the sentence be inscribed among the discourses of knowledge (8).

These insights provide the basis for analysing the emergence of prison medicine in the eighteenth and nineteenth centuries. There are, however, a number of dimensions missing in Foucault's work which are necessary to consider in order to arrive at a more analytical account of medical intervention in the prisons at this time.

First, the question of gender in relation to medicine and discipline is marginalised. As Chapter 6 illustrates, doctors and commentators gazed at, probed, tested and attempted to regulate women to a different norm than that which applied to men. The mystery of women's nature, the intractability of female prisoners and the subsequent management of their lives inside led Arthur Griffiths, the former governor of Millbank prison, to comment that it had been officially recognized at the beginning of the twentieth century that "the most effective government is that exercised by a doctor; so many questions of hyper-emotional temperament, of hysteria, of peculiar physical conditions arise, that the chief official in every large prison today is invariably a medical man" (9).

Second, the role of the doctors in discipline was not an all-encompassing process, nor did it unravel uniformly and without conflict. Medical discourse was never easily or silently accepted. In nineteenth century prisons doctors' accounts were challenged and their competence questioned. Some were dismissed.

Policies around medicalisation were often strangled at birth, or emerged from the womb of the disciplinary society sometimes stunted, occasionally inhibited, usually unsure and uncertain. In that sense, medical discourse was not as over-powering as Foucault implies. It could also sometimes be based on benevolence and concern rather than on the will to power. As Michael Ignatieff has pointed out, Foucault's understanding of the emergence of the disciplinary society, the savoir, "effectively forecloses on the possibility that the savoir itself was a site of contradiction, argument and conflict" (10).

Third, the regulation and disciplinary role of the doctors and other medical personnel was not applied uniformly. Particular groups within the body of the prison - the difficult and the recalcitrant - came in for greater attention from their gaze. If prisoners, in general, were regulated back to the norm, then these groups posed more fundamental problems of regulation and control. As I shall indicate, the doctors spent much of their time, not only probing the dynamics of these groups but were heavily involved in co-ordinating the prison's response to them.

Finally, the practice of medicine, particularly from the 1870s was increasingly influenced and co-ordinated by an incipient state bureaucracy. This dimension, especially in the English context, is missing from Foucault's work. That co-ordination allowed a degree of uniformity between institutions to develop, although how much is still a matter of sociological debate (11). At the same time, the appearance of a more developed and centralised state apparatus provided the space and legitimacy for medical

personnel increasingly to make interventions into the lives of the confined. It is on this terrain through a critical reading of Foucault's work, that the historical origins of the P.M.S. will be considered.

### The Genesis of Prison Medicine.

The conventional starting point for dating the origins of the P.M.S. is 1774 when the Health of Prisoners Act (14 Geo. III C. 59) was passed. This Act empowered Justices of the Peace to make interventions into the administration and running of the prisons in order to ensure the maintenance of health standards in the institutions. Within the Act, the Justices could order the scraping and whitewashing of walls at least once a year, the provision of sick-rooms and ventilation, as well as regular washing and cleaning facilities. Additionally, they were "allowed to appoint 'an experienced Surgeon or Apothecary' paying him from the rates; he was to report on the health of the prisoners" (12). While a surgeon had been appointed at Newgate gaol as far back as 1692 (13) and some houses of correction had employed surgeons from their earliest days, this Act was the first of its kind to make statutory provision for medical care for the confined.

The rationale for the Act lay not simply in the concern for the health of the confined but with the escape of 'gaol fever' from the overcrowded, pestilent prisons into local communities. It could have devastating results on all classes in the community, striking at random and with deadly effect. The 1774 Act and the

concerns that it encompassed, was given further support by the activities of, and interventions by, a number of prison reformers who highlighted the desperate state of the prisons in the late eighteenth century. The most famous and lauded of the reformers was the Bedfordshire landowner, John Howard. Howard systematically recorded in minute detail, the anatomy of every prison in the country and published the results in March 1777 in his seminal work, The State of the Prisons. It was, as Michael Ignatieff points out, one of the first publications to "attempt a systematic statistical description of a social problem" (14).

From the point of view of the present study, Howard's importance in the genesis of prison medicine was crucial. There is, however, an important qualification to be made here with respect to the ideological impact of Howard's work and the policy implications of his interventions. At an ideological level, Howard's views on prison reform were tied into a more fundamental understanding of the nature of crime and disease. As Ignatieff argues, the role of the doctors in prisons was one which was based as much on discipline as on a concern for the health of the poor:

The sicknesses of the poor were interpreted as the outward sign of their inward want of discipline, morality and honor ... The poor were "bound in the chains" of addiction to riotous living, sexual indulgence and intemperance. They were susceptible to disease because they were susceptible to vice (15).

It was from this starting point that the hygienic rituals in the prisons introduced by the medical reforms of the late eighteenth century, were designed to "fulfill disciplinary functions" precisely because disease in institutions was regarded as having a

moral as well as a physical cause:

Like the hospital, the penitentiary was created to enforce a quarantine both moral and medical. Behind its walls the contagion of criminality would be isolated from the healthy, moral population outside. Within the prison itself the separate confinement of each offender in a cell would prevent the bacillus of vice from spreading from the hardened to the uninitiate (16).

Howard represented and crystalised the views of medical practitioners and social commentators of the time. The powerful voices of these organic intellectuals, speaking for the rising industrial bourgeoisie, set the parameters within which crime and deviance was understood. The morality of the poor, the sobriety of their habits and the concern for social order provided the wider canvas on which the Prison Medical Service developed. Dr John Aikin's pamphlet on The Character and Public Services of the Late John Howard published in 1792, extolled his life in the public arena and his efforts to improve the conditions of the poor by giving them "a sober and useful education." This included establishing schools for both sexes where girls were to be taught reading and needlework "in a plain way" while boys were taught reading, the rudiments of arithmetic and some were taught writing. Importantly, Aikin also clarified Howard's conception of medicine in prison and the relationship between health care inside and the demands of the new industrial order. If health care was to be provided, it had to be done in such a way which did not better or indeed equal the care that those beyond the walls received. Less eligibility was a cornerstone of Howard's programme:

he convinced himself that it was the duty of every society to pay due attention to the health and in some degree, even to the comforts of all who are held in a state of confinement .... It was, however, by no means his wish .... to render a prison so comfortable an abode that the lowest order of society might find their condition even bettered by admission into it. On the contrary the system of discipline he desired to establish, was such as would appear extremely grievous to those of an idle and licentious disposition (17).

The link between vice and disease was commented on and highlighted by others involved in the establishment of the early P.M.S. In 1795, J.M. Good who was the physician at Colbath Fields prison responded to a request from the Medical Society of London by publishing A Dissertation on the Diseases of Prisons and Workhouses.

In the publication he argued that "the greater number of all disorders in prisons and workhouses proceeded from inattention to cloathing and cleanliness" (18). He contended that infirmaries in prisons should be constructed in a detached building in the most unfrequented spot in the institution, that the beds should be kept at a distance from each other and that the windows should be large, long and well-ventilated. Water closets should also be introduced while food should never be permitted to be cooked in the wards. With these medical and other changes, he felt that:

the institution will flourish, the concerns of morality and religion will prevail, the grand object of this dissertation will be attained, and the poor will be cheerful and happy (19).

Good had long boasted of his friendship with Howard as a source of "high benefit and advantage" to himself (20). He argued that illnesses such as ulcers, the itch and venereal disease which were common in the prisons and poorhouses did not originate in such



places of public confinement but were "solely introduced by those who enter in consequence of prior vice, misfortune or uncleanness" (21). Disease derived from "want of pure air, want of exercise and proper diet, depredations of spirit, exposure to cold and uncleanness." He concluded with his views on the construction of institutions:

Prisons and poorhouses should be built on the brow of a hill so that fresh breezes could blow over it. Within the institution, if there was any room allotted for common intercourse it should be large and lofty, the night rooms should not be crowded and a bedstead and bedding should be allocated to each individual. Great advantages to health result from private and solitary cells (22).

John Fothergill, another medical man, was Howard's closest friend "and eventual co-adjutor on the penitentiary commission of 1779" (23). Fothergill's protege, John Lettsom, who was also a doctor, wrote Memoirs of John Fothergill. This was published in 1786. Like Good, Fothergill was also interested in constructing places of confinement which would, through their regime and architectural design, relieve both the physical and psychological dangers to the individual that the old prisons brought:

Certain it is, that the indiscriminate confinement of many persons together is productive of two unhappy inconveniences; the first as it affects the body by generating infectious diseases; and the other, as it contaminates the mind by hardening the vicious, and by their example depraving those not already abandoned ... in attempting to prevent those injuries and diseases which human contagion produces they [Howard and Fothergill] united their labours (24).

According to Lettsom, Howard and Fothergill recommended the building of detached or penitentiary houses "as a mode of punishment calculated

to refrain indolence and vice" (25). Fothergill's involvement with the poor extended beyond the prisons, to the foundling hospital at Ackworth to which he left money in his will for its support in perpetuity. The hospital was described by Lettsom as being in a:

most flourishing state, fully answering the design of its founders; being conducted under the care of a number of chosen guardians of ability and of exemplary conduct, with an exactness of order, decency and propriety extremely striking and perfectly pleasing to all who have visited it ..... The children are taught habits of regularity of decency and respectful subordination to their superiors .... those habits of silence and recollection taught and practised in the ancient schools of philosophy, inculcated in the Scriptures and most emphatically called the true door of entrance into the school of wisdom (26).

Lettsom, himself, was also deeply involved in the prison reform movement. He was consulted on the disinfection of Newgate after the death of Lord Gordon in the prison in 1793. He took a leading role in commissioning a statue to Howard's memory in St. Paul's Cathedral. He published James Neild's critical accounts of the prisons between 1803 and 1813 (27). He also published a range of pamphlets on his own ranging from hints on crime and punishment, on schools for the poor and repositories for female industry and hints on female servants. In addition, he was President or Vice President of a number of voluntary societies such as those for the Suppression of Vice, for the Encouragement of Good Servants and for the Publication of Select Religious Tracts.

Howard's reputation reverberated into the next century. William Guy, who was, as I shall indicate below, a central figure in the development

of prison medicine in the late nineteenth century, published John Howard's Winter's Journey in 1882. Guy pointed out that Howard had prepared himself for understanding disease through study and "by intercourse with the best physicians of the day" (28). His discussion of the diseases in the prisons provides, once more, a clue to the parameters within which the reformers worked and the ideological terrain on which they stood. He was particularly interested in jail distemper which he saw originating:

among prison scenes in which it is hard to say which was most conspicuous, the disgusting filth, the reckless depravity, the lawless violence, the gross imposition or the helpless inaction of the state. One cannot think of it without horror or speak of it without disgust. Such a combination of physical and moral evils, such a seething mass of crime, misfortune, low vice and debauchery the world has never seen beyond the limits of England (29).

At the end of the eighteenth century, then, health and illness were profoundly social processes both with regard to how they were explained and the responses that these explanations generated. Howard and the other reformers were clear about what should be done about disease in the prisons in order to preserve the health of the confined. That understanding was, as I have indicated, couched in terms of morality and discipline. As Sean McConville has pointed out Howard "was able to blend perceptions and recommendations" on the issue of gaol fever:

with a similar interest in moral pollution and contagion. Just as prisons generated pestilence they increased depravity and crime, with equally deleterious consequences. In a small, mainly settled and rural society likely to connect death with disease and wrongdoing, this repeated association in Howard's work could not fail to have a considerable psychological impact (30).

There are, however, a number of other sociological points to be considered before a full appreciation of the origins of the P.M.S. can be arrived at. First, although the health of the prisoners, the generation of disease and the notion of ill-discipline and depravity that underpinned them was a central concern of the reformers, the actual implementation of reform was a slow, cumbersome and fitful process. While the reformers' views were supported by the more general ideological position of the newly emerging bourgeois class, the attempt by that class to achieve hegemony was a long and often bitter exercise. This is important for the "new engine of power and authority" which David Philips indicates as emerging during this period, involving rationality and predictability in the operation of criminal justice(31), was not achieved overnight but was struggled against, fought over and in many areas resisted. In that sense reforms were not simply slotted into place.

Second, medicine itself was in a state of flux. Knowledge was scanty and fragmented. The profession did not speak with one voice. There were conflicts between the three branches that made up the medical service in England and Wales: the surgeons, physicians and apothecaries (32). This point becomes important when we consider the anatomy and role of prison health workers in the nineteenth century.

Finally, those who began working in the prisons at the end of the eighteenth and the beginning of the nineteenth century were not working on a terrain co-ordinated by the state. This point too is important to recognize if we wish to develop an under-

standing of how professional groups became state servants. That co-ordination was to emerge in the 1870s in the shape of a recognizable state formation that brought together the diverse elements of the P.M.S. under one central umbrella. Until then, the P.M.S. remained relatively unco-ordinated. Crucially, however, medical workers did operate within a particular ideological framework which, as I have indicated, both explained criminality and legitimated the kind of penal regime that should prevail in order to deal with the criminal. From the outset prison medical discourse was caught up in and reflected the wider concerns of a society whose industrial and cultural revolution was beset by internal problems of ill-discipline, instability and class fear. As I shall indicate, there were conflicts over, and resistance to, the imposition of this discourse into the lives of the confined. But if the criminal was increasingly becoming a prisoner behind the walls of the newly built penitentiaries, then prison medical workers were also prisoners of an ideology that explained criminality in relation to ill-discipline and of a class that demanded an answer to this ill-discipline and the criminality, deviance and disorder that flowed from it.

#### In the Shadow of the Penitentiary: The Development of Prison Medicine.

Gloucester prison provides an important early example of many of the themes outlined above. The new prison was opened in July 1791. Under the influence of Sir George Onesiphorous Paul the old prison had been reformed but in a manner which "would

not compromise the deterrent value of punishment" (33). Hygienic rituals and regular medical attention were amongst the reforms introduced. They were, however, not outside or above the more general concern with reconciling reform and deterrence. In 1784, in a report to the justices, Paul wrote of the importance of shaving the heads of prisoners "both as a measure of hygiene and as a salutary humiliation":

.... so far as shaving the head is a mortification to the offender, it becomes a punishment directed to the mind, and is (at least so I have conceived) an allowable alternative for inflicting corporal punishment intended to be excluded from this system (34).

As Michael Ignatieff concludes "the medical rituals that accompanied admission to the penitentiary had a latent but explicit purpose of humiliation" (35).

From the outset this disciplinary role was important for the medical workers in the prison. Both the prison surgeon, Dr Parker, and the physician, Dr Cheston were involved with helping to detect if prisoners were feigning madness. Parker recounted the story of a prisoner who appeared to be feigning madness. As he noted in his journal he seemed:

to all appearances speechless, after some time I discovered the deception, I forced down a stimulating medicine which soon brought him to his speech. He is now very abusive (36).

When another case occurred in October 1796, Parker called in the prison physician, Cheston. Once more, the surgeon's journal recorded the events surrounding the behaviour of the felon Thomas

Roberts. Roberts had attempted to escape. After being caught he was placed in the dark cell whereupon he became sullen and deranged. In order to test whether he was in fact insane, Dr Cheston suggested that he should be plunged into the cold bath:

After 20 minutes in the bath, Roberts made several attempts to relieve himself by leaning against the sides, but he was pushed off each time (37).

Roberts finally repented but within 24 hours the treatment was tried again. This time the victim was Honor Oliver, a gipsy. She was given three dippings on 28th October and was then strapped to her bed. There were other cases in 1798, 1807 and 1811. In the last year Hester Harding was arrested for want of sureties. She was put in the infirmary with a sore throat:

When better, she affected insanity and had to be strapped down. She was given a cold bath, with a little hot water added to it, as it was December. It had little effect on her, and a straitjacket was tried and this succeeded. But when faced with Martha Jeynes' insanity an electric shock was tried instead, which the surgeon noted, 'I am pleased to say produced an immediate desired effect, she fell on her knees, confessed and promised to conduct herself properly in future'. The 'Electric Machine' was used again when she became obstinate, but without effect so the surgeon 'directed the Turnkey to drench her with Beer Caudle', and this proved effective. She was serving two months for stealing butter.

The electric shock treatment was not tried again but the cold bath was used twice more in 1816 (38).

The concern with discipline was one of a number of duties the surgeon performed. He was also responsible for the assessment of the mental and physical health of

the prisoners, the administration of appropriate medicines, ensuring against the introduction of lice and contagious diseases into the prison and "ordering such easement in discipline or supplementation of diet as might be required":

In these matters, the governor was obliged to comply with his recommendations though the surgeon's directions of individual easements in the discipline had to be reported to the justices (39).

Additionally, the surgeon was also obliged to see each prisoner at least twice a week and simultaneously ensure that the governor was not abusing or ill-treating the prisoners. Both he and the prison chaplain in that sense theoretically regulated the governor's conduct.

The rules and regulations governing the role of the surgeon in the new penitentiary at Millbank covered similar terrain. He was to live in the prison, attend all sick prisoners, was not to have a practice outside of the walls and was to examine all prisoners on their arrival in the prison. He was further instructed to visit every part of the prison and to visit both male and female prisoners in their respective infirmaries. Finally, he was also instructed to:

acquaint the Governor or Matron with the necessity of suspending the discipline or varying the diet of any prisoner, and the Governor or Matron shall give direction accordingly. He shall attend on notice from the Governor or Matron, of the confinement for any offence, or the punishment by change of diet, of any offender within the prison, and shall visit every prisoner, concerning whom he shall receive such notice, once in every day as long as such confinement or change of diet shall be continued (40).



The question of difficult prisoners, and the involvement of prison medical workers in dealing with them was also a central concern for this regime. The prison was opened in 1817 at a cost of £450,000 an enormous sum of money for the time. From the outset prisoners rebelled against the "regime of solitude, hard labour and meager diet" (41). Prisoners also complained about the brutality of prison staff and demonstrated their resistance to the regime by smashing their cells, fighting with the guards and rioting in chapel. Even in the solitary silence of the dark cell they continued to shout encouragement in support of each other. At an individual level these collective protests were mirrored by prisoners pretending to be dumb. In his history of the prison, published in 1875, Arthur Griffiths who had been a governor in the Victorian prison system, described what happened in such cases:

This man when brought before the governor continued obstinately dumb. The surgeon consulted was satisfied he was shamming but still the prisoner persisted in keeping silence. 'Is there any reason why he should not go to the dark?' the surgeon was asked. 'Certainly not, on the contrary I think it would be of service to him'. And to the dark he goes, where he remains for six days till he voluntarily relinquished the imposture (42).

The dark cells were situated underground and measured nine feet by six feet. They were reached by a passage that was both pitch black and so narrow that prisoners could only pass through it by walking sideways:

The only light for the occupant during the entire period of punishment was that brought by the turnkey when he delivered food three times a day. Evidence was given to the 1823 select committee (without provoking adverse comment) that convicts, male and

female, had been kept in the cells for as long as three weeks. There was no heating and no removal for exercise; and as it is known that other parts of the prison achieved afternoon temperatures of only 46 degrees Fahrenheit during the winter of 1822-3, the cold in the punishment cells must have been intense. Physical conditions apart, there is no doubt that the psychological damage caused by prolonged sensory deprivation made this a terrible punishment indeed. That prisoners so confined could not have escaped severe damage to their health, especially as the food was usually only bread and water, was well recognized since as a matter of course they were taken to the infirmary after this ordeal (43).

Millbank, itself, had been the centre of major controversy when an outbreak of scurvy occurred and 31 prisoners died. The Medical Service had been deeply implicated in what had occurred. In particular, the physician and the surgeon had cut the prisoners' already meagre diet in response to outside pressures which demanded a harsher attitude towards the incarcerated. At the meeting of the Superintending Committee on 19th April 1823, the Committee resolved to remove Dr A. Copland Hutchinson from his position as Principal Medical Superintendent to the Penitentiary. He was removed from the position on that day. The Committee's action had followed a report prepared at their request by two outside doctors, Latham and Roget, which had concluded that the outbreak of scurvy had been principally caused by the diet in the prison. The doctors made particular reference to the question of the diet, an issue that was to reverberate through the nineteenth and into the twentieth century:

during the last eight months the diet was different from what it had been since its establishment. The change which took place in July last, reduced the animal part of the diet almost to nothing. In a soup made of pease or barley, oxheads were boiled, in the proportion of one oxhead to 100 male and to 120 female prisoners: and we found upon inquiry, that the meat of

one oxhead weighed, upon average, eight pounds, which, being divided among a hundred, allows only an ounce and a quarter for each prisoner. This new diet had been continued until the present time; and to it we mainly ascribe the production of the disease in question (44).

Hutchinson, who had been the M.O. at Millbank for seven years, subscribed to the view that the previous diet which the prisoners received was "rather too much" and had contributed to a "fulness of habit" amongst them (45). It was in response to this 'fulness', the apparent rise in crime, the lack of deterrence and the general insubordination amongst the prisoners themselves that the doctors had involved themselves with reducing the prisoners' diet.

The events at Millbank, and the role of medical staff in these events, illustrate one of the central issues regarding the work and role of the early P.M.S. The issue of internal prison discipline and external social discipline intertwined and overlapped and emerged as the ground on which the doctors stood when making their judgments about prisoners. Additionally, the state of medicine was such that the doctors' involvement in constructing dietary scales for the confined meant in practice that they were, in the words of Dr Latham, engaging in 'experiments' with the prisoners' bodies and minds. In his account of the disease published in 1825, Latham specifically referred to this point when he wrote that:

With regard to the diet of prisoners undergoing punishment for crimes, we presume the object to be that they should have enough for nourishment and health and nothing more. How much and what quality of food will actually suffice for this purpose can be deduced only from numerous and careful experiments. But no such experiments as far as we know have ever been made (46).

This experimentation, attempting to precisely calibrate and quantify the last crumb of food and the final drop of liquid due to prisoners, was indeed to play an important role in the lives of the confined. It was underpinned by the increasing demands from, and impact of, the principle of less eligibility on the managers of the prison system. Frederic Hill, one of the five inspectors of prisons, caught the mood of this principle when he wrote:

While it is right to give prisoners such a quantity of food as will keep up robust health, it is important to allow nothing beyond what is really necessary, both because excess of food is injurious to health as well as deficiency, and because the motives to honest industry will be weakened if anything like luxury be admitted into prisons (47).

These early concerns around discipline and health took place in the context of a system where the changes advocated by Howard and the other reformers had not been introduced in any great measure. Conditions inside remained deplorable, while abuses of the confined continued to arouse comment from politicians in particular. In the summer of 1814 Earl Stanhope raised a series of questions in the House of Lords about the treatment of prisoners in Gloucester and Bristol prisons. Stanhope presented petitions both from prisoners and their relatives challenging the legality of the actions of the gaolers in opening prisoners' mail to their legal representatives. This was in the more general context of a series of other abuses including confining prisoners to a solitary cell without pen and paper, eating food without knives and forks, being only allowed to speak to friends and family through a square hole in the presence of a turnkey and

the intimidation of families when they visited Gloucester prison (48). On 20th July, Stanhope read a petition from Hannah Jackson whose husband had been imprisoned in a dispute over a bill for work that had been done for him. In prison, he became ill and subsequently went mad:

He was deprived in prison of all proper means of medical treatment; and after much cruel treatment, was locked up in the strong room where he was kept until the day before his death .... The coroner's jury who sat on the body brought in a verdict that the deceased had died in consequence of close imprisonment and want of proper advice. The doctor affirmed that if the deceased had been permitted to have a strait-jacket, he would, in all probability have recovered; and it had been further stated to the petitioner, that her husband's body had been found to be covered with bruises (49).

A similar petition had been presented in the House of Commons the previous month. On 27th June, Henry Grey Bennett presented a petition from Mrs Booth whose husband had died in the King's-Bench prison. Her husband had also been arrested for debt. At the time of his arrest he was seriously ill. Nonetheless, he was transported by cart to prison where he was placed on a bench where "he remained until the humanity of some of the prisoners conveyed him to a bed, in which after a short time, he died." The Coroner's jury returned a verdict that he had died from natural causes but that his death had been considerably accelerated by his imprisonment and the treatment to which he had been exposed (50).

Petitions were also heard on behalf of women prisoners. On 30th June, Mr Bennett raised the case of Mary Anne Clarke, who had been confined in the King's Bench for libel. The petition

stated that she had suffered great partiality and oppression in the prison at the hands of the Marshall. This had resulted in Mrs Clarke becoming ill:

She was confined in a cell nine feet square, of which her bed occupied a considerable part, and which had but one small window, barricaded with iron. The approaches to her room were so obstructed that even her medical attendants found it difficult to access .... At ten o'clock, contrary to the ordinary regulations of the prison, her cell was locked and no one, not even a physician was permitted to visit her. Her illness had brought on a nervous fever, by which she was so enfeebled as to be hardly able to walk ..... (51).

It is clear from these accounts that reform of the regimes was a slow process. As I have indicated it was also a process that unfolded against the background of ensuring that prison regimes did not become overtly comfortable. The reformers thus tried to walk a penal tightrope which on the one hand demanded change via improved conditions, while on the other arguing that these changes should not undermine the disciplinary character and moral thrust of the prison regime. If the reformers walked the tightrope, then it was the doctors and prisoners who held the rope up. Both groups were central to the interests of the reformers, doctors and surgeons because they would be involved in monitoring the programmes, prisoners because they were at the end of the process, the group for whom the programmes were intended. Joseph Gurney's journey around the North of England and Scotland with his sister Elizabeth Fry in the summer of 1818 encapsulates these problems. His views published in book form the following year described the conditions they witnessed and the reforms they desired (52). The most conspicuous

and fatal evil in Gurney's eyes was "evil association accompanied with total idleness" (53). In order to obliterate these conditions, Gurney suggested a number of reforms around clothing, sleeping, cleanliness, classification and employment. On the question of food he attempted once more to achieve a balance. He argued that insufficiency of food was an evil and that "we are not justified in making inroads on the health of our prisoners." On the other hand:

unnecessary indulgence either in the quantity or quality of food is very undesirable, and much opposed to a judicious system of prison discipline (54).

George Holford, another leading prison reformer and chair of the committee of MPs which supervised the construction of Millbank articulated similar views. His Thoughts on the Criminal Prisons of This country was published in 1821. In this tract he complained that "the prisoner no longer feared disease, hunger, heavy irons and no bedding but proper sufferings and privations had not been substituted" (55). It was a question which was to be central to the reform of institutions in particular and the poor law in general throughout the century. In 1841, the dangers of a pauper medical service that was too efficient was highlighted in the 7th Annual Report of the Poor Law Commissioners:

If the pauper is always promptly attended by a skilful and well-qualified medical practitioner .... if the patient be furnished with all the cordials and stimulants which may promote his recovery it cannot be denied that his condition in these respects is better than that of the needy and industrious ratepayer who has neither the money nor the influence to secure equally prompt and careful attendance nor any means to provide himself and his family with the more

expensive kind of nutriment which his medical superintendent may recommend. This superiority of the condition of the pauper over that of the independent labourer as regards medical aid will .... encourage a resort to the poor rates for medical relief (56).

As Derek Fraser succinctly puts it:

less eligibility was always the keystone of the new Poor Law; hence the medical treatment of paupers had to be inferior to that which an independent workman could provide for himself (57).

The Lancet captured the spirit of these feelings when it compared the grant allocated to the prison at Millbank with that set aside for the sick poor of 15 parishes. The latter whose hours and days were characterised by "habits of industry" were to receive less medical aid than those in the prison. The journal felt that through this grant "the sanguinary cruelty which characterises the treatment of the sick paupers in the Unions is rendered most conspicuous" (58).

This principle intensified the harshness of the already severe penal regimes. It was also to increase the intensity of the debate about what was happening to those at the sharp end of this punitive calibration. For particular groups, such as those who died in custody, the debates came too late. On the other hand, these deaths only served to show that the state of the penal regime and the medical treatment attached to it, could, quite literally, be a matter of life and death.



Dying for Help.

The question of deaths in custody had been a source of controversy since the end of the eighteenth century. In Coldbath Fields prison, constructed in 1794, 376 prisoners died between the years 1795 and 1829. Eighty five of these deaths (22.6%) were women. The analysis of these figures by T.R. Forbes has indicated that the causes of death were described as ranging from 'visitation of God' to 'decay of nature', 'dropsy' and 'decline, debility'. In 123 cases the cause was not stated. As Forbes points out, a close scrutiny of the list of these causes reveals:

an apparent lack of official interest in determining why prisoners died. Indeed one wonders whether the vagueness of the record represents an effort to conceal actual causes of death - a state of affairs which would not be surprising in a prison in utter disrepute. No cause was recorded for almost one third of the deaths. Almost one-fifth were piously ascribed to a "visitation of God" a whitewashing phrase that also was frequently used by coroners' juries of the time for deaths in prison; it was as nonspecific as it was unassailable. "Decays of nature" referred to a decline in physical vigor and must have been nearly synonymous with "debility". "Dropsy" of course we would regard as a symptom rather than a disease. These six listed causes account for 85% of the deaths; what actual diseases were responsible we can only guess (59).

Visitation of God as he indicates, was a highly problematic, yet frequently cited, verdict brought in by inquest juries. In 1828 there were inquests on 14 prisoners and on six the following year. In all 20 cases, the verdict was visitation of God .

Such verdicts were not always accepted without criticism. Indeed it was recognized by a number of commentators that the Coroner's

court was a wholly inappropriate forum for highlighting the exact details of deaths in prison and appointing blame. At the second reading of the Coroners Bill in the Commons in March 1816, Mr Swan pointed out that for paupers in particular, and those who had no friends or relatives to look into the causes of death, the Coroner's inquest was conducted as a "matter of course" (60). The Lancet in a series of articles which continued throughout the nineteenth century talked of the "imbecility and ignorance of Coroners" (61) and how the discrepancies in the courts arose from the lack of medical knowledge of the Coroner who was often a lawyer:

A lawyer in the shape of a coroner! A man who could not apply a plaster to a sore finger but who will explain to you the anatomy and physiology of the brain and the surgical treatment of its various antecedents in 3 or 4 brief sentences. Here, also let us hope for a speedy and effectual reform (62).

More specifically, Dr William Farr argued that inquests held on those who died in prisons were "very much a matter of form" and that overall "the causes of death registered as the result of solemn judicial investigation, are among the most unintelligible in the register" (63). In 1830 Colonel Blenner Lasser Fairman wrote to The Lancet complaining that when deaths occurred in prisons, the jailers fearing that their prison could be closed did "everything in their power to keep these calamities from knowledge of the public" (64). He argued that the juries were packed with the jailers' tradesmen, that the proceedings were hurried and that obstructions were placed in the way of those who wished to attend the court. He went on to complain that

the lawyers were "more or less" connected with the governors of prisons, that they were subservient to the judges and stood identified in some measure with the courts. He concluded:

'Died by the visitation of God' is the return nine times out of ten when the verdict ought to be of 'a broken heart through persecution of the most relentless or unjust' - 'of disease brought on by a removal from a bed of sickness to a place of incarceration' - 'of abstinence and starvation through the absolute want of the comfort and necessities of life' - or perhaps 'from excess of drinking brought on by anxiety and dejection of mind, through a long confinement' (65).

Coldbath Fields and Millbank were not the only prisons where deaths were common. Dartmoor too, was a place where there was controversy around the deaths of the confined. Again, the medical treatment that they received was a central element in the controversy. In January 1810, a letter signed "W.W." was received by the Admiralty and alleged that "there were then 700 sick in the prison hospital and that medical attendance was utterly inadequate" (66). The prison contained French prisoners one of whom left a diary of the events. This forerunner to more contemporary autobiographical accounts described:

with some bitterness ... the callousness of the hospital staff. It is alleged that when the epidemic was at its worst the doctor had coffins stored in the infirmary in full view of the patients who were further "encouraged" by hearing their medical attendant say to an assistant, "The more deaths, the fewer enemies" (67).

A similar story emerged at Lincoln prison in June 1812. In the House of Commons Sir Samuel Romilly raised the case of Thomas Holden, a debtor who, while in the prison, complained of oppression.

He was kept in solitary confinement for eleven days in one of the condemned cells under the prison. When the matter was raised in Parliament he was released. This case prompted another MP to raise the case of a prisoner named Godfrey. He was confined in the same prison and had been troubled with a severe bowel complaint. After receiving medicine he had a relapse. His cries disturbed the other prisoners who asked the turnkey to assist him. After some delay, medical assistance was called but the prisoner died. It was pointed out that "on the coroner's inquest were sworn men under the influence of the governor of the prison" (68). On 25th June the same MP developed his criticism from statements made by 12 prisoners who saw what had transpired. They asserted that:

Evans, the surgeon in a conversation with these persons previous to the Inquest gave a very different account of the transaction from what he thought proper to give afterwards. They also assert that the conduct of the Coroner was very improper in several instances. He told the Jurors there was no alternative between bringing in a verdict of "Murder" or "Died by the visitation of God" which induced the Jurors to bring in the latter verdict, though three of them afterwards said, they thought it would have been more proper to declare, that the prisoner died through the negligence of the gaoler or his servant (69).

The confinement of the orator and activist Henry Hunt in Ilchester gaol brought the conditions inside into sharp focus. There were a number of debates both in the Commons and the Lords throughout 1822 that highlighted his plight including being kept in solitary confinement. When he became ill he was refused permission to see his own doctor. Instead a doctor who lived 5 miles away was brought in. MPs argued that there was no control in the

prison "the gaoler was not checked by the surgeon, the surgeon by the coroner nor the coroner by the magistrates" (70). The gaoler subjected prisoners to severe punishment including the application of a blister to the head of Thomas Gardiner. For another prisoner named Hillyer, the treatment was even more severe. Double irons were placed on his arms and legs and the chain with which they were connected was so short that it was almost impossible to stand upright. A third prisoner named Mary Cuer was also placed in solitary confinement and held in irons for four days in a cold, damp cell. She was accompanied by her child whom she could only feed bread and water from a bucket. A fourth prisoner named Treble had died from the cold but his death had taken place in the common-lodging room "subject to all the noise and disturbance created by other prisoners" (71). Out of 600 prisoners, 400 had been found to be ill due to the conditions. At the inquest into the death of James Bryant, the jury heard that the gaol had been flooded six times in as many weeks. Furthermore:

there was no room in which the deceased could sit with a fire in it during his illness, that was not at least six inches deep of water. The jury, upon hearing the evidence, declared that the deceased had died by the visitation of God; but added, that the event had been accelerated by the damp state of the prison (72).

In a major Parliamentary debate on the subject in April 1822, Sir Francis Burdett, who had been forceful in his claims for Hunt's release, pointed to some of the deficiencies in the gaol that had been highlighted through his inquiries. The role of the doctor was discussed in relation to Hunt's demands for

treatment by his own M.O.:

Mr Hunt preferred trusting to nature and a good constitution rather than place himself in the hands of this humane gaol doctor. It was not enough that there were to be found in that prison, chains, stocks, handcuffs. No, this would not do. There was a doctor who did not hesitate to apply a blister to the head of a man in irons. Why? Because he was ill? No such thing. The blister was applied because the man was considered to be - "a troublesome fellow" (73).

Burdett discussed the case of three other prisoners who had also been blistered: the first in order to "mend his manners"; the second because he was a "troublesome jockey"; and the third, who was blistered on his side, because "he shammed". The MP concluded by asking:

Was it surprising that, with these facts before him, Mr Hunt should decline availing himself of the assistance of this kind and humane doctor? (74).

As I shall illustrate in Chapter 5 this issue, and the medical profession's role in it, was to be a central concern right into the 1980s. For the moment, it is worth considering other aspects of the issue in greater depth, particularly the impact of the 1834 Poor Law on those confined in the prisons. The impact of the new law was felt by a P.M.S. which in the 1830s and 1840s was still haphazardly organized and left to the devices and discretion of local practitioners. The reports by the Inspectors of Prisons established by the recommendations of the 1835 Select Committee on Gaols indicate the state of medicine in the prisons at this time. The first report by the Inspectors contained this description of Ipswich Borough Gaol:

The surgeon does not inspect the prisoners before they are classed. He is present at corporal punishment. The itch has been communicated from one to another within the prison. There is no infirmary .... The surgeon keeps no register, nor book of any sort, the Magistrate never requiring him to do so (75).

In the second report, the Inspectors made similar comments about Gloucester, pointing out that the ventilation was very defective, that the cells were damp and that the infirmary was:

not fit for the confinement of a sick prisoner. Scenes of disorder are a perpetual occurrence. The only punishment resorted to for convicts is punishment in the dark hole. The place is not in any degree ventilated and is so situated that the prisoner under punishment can talk with the prisoners outside. This constantly occurs when a female prisoner is confined in the dark hole (76).

These conditions were compounded by the passing of the Poor Law, which, as I indicated above, meant that medical services in institutions were set at a level lower than that which the 'respectable' labourer received outside the walls. By 1837 The Lancet was already highlighting the impact that the changes were having on the lives of the confined. In an editorial comment, the journal argued that prisons should be sites for reformation and not places of punishment or torture. Additionally, the writer felt that the confinement process had been combined with:

Some injunctions of a most intolerable character. The "silent system", the limitations of a bread and water diet and the refusal of all occupations for the mind except that which is derived from a perpetual perusal of the Bible and the Prayer Book during periods extending from six months to several years, have obtained a degree of encouragement which is equally unwise and disgusting and ought to receive an immediate check (77).

The editorial concluded that education in general should be available to the confined for:

to turn criminals out upon society, even a shade worse in health and ignorance than distinguished them when they entered the dungeons of a gaol is in itself a crime of the very worst description (78).

The journal continued its attack the next year. Its target was Edwin Chadwick, the architect of the new Poor Law. The authors cited, in particular, the reduction of dietary provision in prisons and the impact on mortality rates. The journal challenged Chadwick's data on death and diet from which he had claimed that those on the lowest diet were the most healthy and that a full diet was the source of sickness and death. As with his data on the Poor Law in general Chadwick's figures were scrutinised (79). The results were "erroneous, the data having been ingeniously collected but inaccurately interpreted" (80). The journal examined his figures and tables in detail and found that cases of sickness had never been entered at some prisons. Furthermore, while every complaint had been entered at those prisons where prisoners received a full diet only those with severe diseases and sent to the infirmaries had been entered "at the gaols where the prisoners are most severely treated" (81). The writers concluded that:

It is only a perversion of words that the term "full dietaries" has been applied to the low scale of food in any English prisons. All the dietaries are low, and the mortality of prisoners whose mean age may be taken at 20-30 is nearly double the mortality of the country population at the same age ... Rogues and thieves when committed to prison, rarely, if ever, labour under any serious disease. On entering they are in health ..... The proper quantity of food for masses of men or animals is the average quantity that



they eat when the supply is regular and unlimited. When subsistence is stopped or reduced much below this standard, the well-known consequences of famine ensue; and every degree below the standard has a corresponding death (82).

In July 1840, The Lancet launched another assault on the reliability of the official figures for deaths in prison. The journal looked, in particular, at Millbank and was quite clear where it stood on the question of prison health. In the first place, its writers noted "the health is impaired and life is shortened by imprisonment" (83). It calculated that in the five years between 1826 and 1831, the death rate in 93 prisons was 16 in 1000. This compared with 10 or 11 in 1000 for England in general. Once again, the journal took issue with the methods by which the statistics were collected. It had made a similar point earlier in the year when its writers criticised the Superintending Committee of the prison for not considering the full dimensions of the statistics surrounding mortality rates. The authors concluded that:

the situation of the Millbank Penitentiary is bad, cannot be disputed; but imprisonment in any place invariably injures the health. The Penitentiary system - involving imprisonment in cells - would produce a high rate of mortality among the prisoners. It has been shown by incontrovertible statistical facts, that imprisonment now destroys ten times as many lives as the executioner in this country (84).

The journal continued to highlight the cases of particular doctors and their role in the prisons, especially when they failed to live up to, or indeed undermined, the good name of medical practice. Thus in the early 1830s, Dr Stevens the M.O. at Coldbath

Fields was charged with exaggerating the number of cholera cases in the prison so that he could treat these cases with the method he favoured, namely saline treatment. The important point for The Lancet was that by using this method prisoners died who ought not to have done. The journal had no hesitation in expressing the conviction that the epidemic at the prison had been "most reprehensibly exaggerated" by both Dr Stevens and the magistrates. Furthermore, "that considering the vast number of 'premonitory' cases included in the cholera list, the mortality rate was greater in this prison than it has generally been elsewhere under the most opposite modes of treatment" (85).

For particular groups of prisoners a sentence could be especially severe on their health. Chartist prisoners are a good example of this. The health of those sent to Northallerton prison was affected by the cold and damp. Three of their number died in the prison in the early 1840s. One of them, Samuel Holberry, wrote to a friend:

They have destroyed my constitution ... I am reduced to such a state of debility that I can hardly crawl .... And dear friend, you may rest assured that I shall never serve two years more in prison; no before half that time has expired I shall be in my grave (86).

Cells were cold and damp, below ground level, with water running down the walls. At Monmouth, Wright Beatty complained of the damp, while at York Peter Hoey lost the use of a leg "which prevented him from returning to his trade as a linen weaver upon his release". The food was particularly bad. It was meagre and coarse:

At Fisherton Gaol, William Carrier had to eat sour bread, not even getting potatoes. He received neither soap nor towels, and wrote that "itch, lice and filth of every description prevails in almost every part of the prison". Many of the Chartist prisoners complained to the inspectors of indigestion and diarrhoea (87).

Some doctors voiced their concerns about the direction of penal policy and its impact on the health of the confined. Frederick Kent, the surgeon at Lincoln complained that he was:

much inconvenienced for the want of an infirmary. There has been no epidemical disease, nor a single death. The prisoners are very subject to constipated bowels and the addition of a small quantity of vegetables to the present diet would, I think, be beneficial. After being here for a few months, I am satisfied the prisoners suffer in health, which I attribute to the want of ventilation and the monotony of the diet (88).

The surgeon of Walsingham County House of Correction wrote that the ordinary diet was:

too low. You cannot keep a man here three months without injuring him, and rendering him incapable of that labour which is required of him to produce the means of self-support. If I did not interfere in this general way and order extra diet I should have nothing but disease; the numerous orders for extra diet in my journal are cases of prevention not of actual disease (89).

The prison diet was thus a central focus of attention both for the managers of the penal system and medical personnel. In 1843 Sir James Graham's recommendation for a table of dietaries (see Table 8 below) was introduced into local prisons and adapted to fit the needs of the convict prisons. From this date dietary scales were up or down-graded in relation to the wider demands

for greater discipline. It was usually the latter programme that was adopted which for some prisoners meant that they "became the subjects of deliberate experiments designed to test the limits of its meaning in terms of their bodily well being" (90):

DIETARIES of COUNTY and BOROUGH GAOLS 1843.

	WITHOUT HARD LABOUR.				WITH HARD LABOUR.			
	Class 1.	Class 2.	Class 3.	Class 4.	Class 2.	Class 3.	Class 4.	Class 5.
WEEK	Less than 7 days.	More than 7 days, and not more than 21 days.	More than 21 days, and not more than 4 months.	More than 4 months.	More than 7 days, and not more than 21 days.	More than 21 days, and not more than 6 weeks.	More than 6 weeks, and not more than 4 months.	More than 4 months.
	ozs.	ozs.	ozs.	ozs.	ozs.	ozs.	ozs.	ozs.
Bread	112	168	140	168	168	140	168	154
Potatoes	-	-	64	32	-	64	32	112
Meat	-	-	6	12	-	6	12	16
TOTAL SOLID FOOD	112	168	210	212	168	210	212	282
	pints.	pints.	pints.	pints.	pints.	pints.	pints.	pints.
Soup	-	-	2	3	1	2	3	3
Gruel	14	14	14	14	14	14	14	11
Cocoa	-	-	-	-	-	-	-	3
TOTAL LIQUID FOOD	14	14	16	17	15	16	17	17

From the prisoners' perspective hunger and ill-health were constant features in their lives. As the Howard Association commented, "a man goes to bed hungry and gets up hungry, in fact he is always hungry; and this lasts for not weeks, not months, but for years" (92). This led to prisoners supplementing their diet with beetles, railway grease, brown paper, earth, candles, poultice, snails, slugs, frogs and earth-worms. They also resisted both through developing an "acute sensitivity to the weight of the food they were given" and through engaging in more collective forms of action in terms of disturbances. They also supported hungry prisoners in terms of redistributing "their irrationally allocated rations on a more equitable basis" (93).

Boils, rashes, spots, indigestion and flatulence were common ailments suffered by the confined. Loss of weight was a frequent outcome of the dietary provision. One prisoner described its ill-effects:

When, by-and-by, he can eat the unpalatable mess provided, he acquires chronic indigestion, dimness of eye-sight, tinnitus aurum, roarings in the head, gastric spasms, shortness of breath, sickly giddiness and absence of staying power generally ..... he may (also) contract heart disease (94).

There were also medical voices raised about the diet which argued for an increase in provision to be made for prisoners. In October 1848, The British and Foreign Medico-Chirurgical Review carried a long article reviewing a book by the Rev. J. Field on the separate system of confinement. Field, who was chaplain at Reading prison, favoured a punitive diet, food that was coarse and although perfectly wholesome should "prevent self indulgence" (95). The

Review rejected this perspective citing cases of prisoners who had lost weight through the reduction in their diet. The writers also drew attention to the prison doctors whom they felt had not been vocal enough in defending the purely medical side of their duties:

Medical men have been too much biassed by the opinions of their masters. They have feared to place prison boards in a difficulty by strong representation of evils which could only be remedied by measures entailing great expense and infinite trouble on magistrates .... The question of expediency and policy is for others; and had the subject been so viewed by our prison officers, the government and magistracy might have had occasion long before this to hold in high esteem and regard a branch of the prison service which now by no means commands the respect it deserves (96).

The writers concluded that many members of the medical profession supported Field's views on prison diets. They had fallen into error "by having taken a low view, not only of the subject, but also of their own position as the highpriests of Nature" (97).

The Lancet also commented on the situation at Reading pointing out that the local justices had stubbornly refused to "adopt even the minimum of food proposed by Sir James Graham" (98).

The mid-nineteenth century was a period in which a number of issues around discipline, regulation and control confronted those medical people who worked in the prisons. As I have indicated, the question of prison diet was a constant source of controversy, particularly in the context of the often-repeated view that prisons were more luxurious than workhouses and therefore the poor could be seen flocking to them. The Lancet summed up these views perfectly in September 1858:

..... let us see what are the consequences of making prisons paradises and workhouses pandaemoniums. In the first place, the prison is greatly preferred to the workhouse as a place of abode by the lower classes. Magistrates, chaplains and visitors acknowledge this to be the case, and the preference is openly allowed especially by the females .... The prison offers a clean and comfortable lodging, food far superior to that of some of the workhouses, and comparatively kind and attentive officers of a higher grade than those provided for the simply unfortunate and starving (99).

This belief helped to justify the calls for greater discipline inside and demands for the perpetual surveillance of prisoners in order to spot malingerers, particularly those who sought to avoid the penalty of the work situation. As Sean McConville points out, this could have a profound effect on prisoners. At Parkhurst prison, when it was recognized that boys were unfit to work and in a poor state of health "they were not spared outdoor labour" (100). When the marks system was introduced, the system only allowed prisoners in the infirmary to earn six per day:

this was sufficient to allow the convict to maintain but not to improve his position with regard to progress through the stages. Medical officers claimed that this had the desired effect on the rate of malingering, as apparently had the use of separate confinement in infirmary cells. John Campbell, a convict prison surgeon for many years, used both galvanism and the cold douche as treatments. He noted in his memoirs that 'Patients suffering from the real disease gladly submit to this or any other remedy likely to benefit them, but malingerers show a great repugnance'. So strong was the determination to reduce to the minimum absences from labour that medicines were administered during meal-breaks. Faced with what was, very probably, a uniformly disbelieving attitude to the claims of all but the most obviously and gravely ill, some prisoners inflicted injuries on themselves in order to escape work (101).

This concern with discipline and regulation was further compounded by the continuing involvement of the doctors in the disciplining



of offenders. The entries for March and April 1858, into the journal of the governor of Bedford prison emphasise this point. On Tuesday 23rd March he discussed how a prisoner named John Robinson had been very noisy and troublesome, had refused to work and had thrown a stone at one of the warders. The governor, the chaplain and the surgeon all felt that he was feigning insanity:

It is therefore necessary that prompt means be adopted to reduce this man to order and regularity. (Sat. 5th April) The prisoner 'Robinson' continues obstinate and does no work. He is still kept under slight restraint at the request of the surgeon to keep him out of mischief (102).

If labelled as troublesome, then a prisoner could be denied his/her request for medical attention. Again the governor's journal highlights this:

May 4 1853 Jones, a government convict complained this evening of being unwell and wished to go to bed. I visited him in his cell and there certainly did not appear to be much (if anything) the matter with him. He requested he might have the surgeon sent for. The surgeon had seen him in the morning and had not left the prison 5 minutes before he complained. I did not grant his request, in either case, he is represented by the Chief Warder as a very troublesome character and exceedingly obstinate (103).

The concern that prisoners should not live in luxurious conditions also meant that doctors engaged in what they termed 'experiments' in an attempt to quantify to the most precise fraction of an ounce the diet most suited to the criminal. The work of Dr Edward Smith was widely reported in medical journals and discussed at conferences in the late 1850s and early 1860s. Smith attempted to precisely

tabulate the kind of diet different prisoners should have and its particular relation to the amount of labour done by the prisoner. This tabulation and quantification came from what the BMJ described as "the results of experiments by Dr Smith in the Coldbath Fields, Wandsworth, New Bailey (Salford) and Canterbury prisons" (104). Smith argued that the prison diet should not be used as a punishment and that the food supplied on the lowest dietary scale "is so totally inadequate to the wants of the system that it can only be regarded as an instrument of punishment" (105). He recognized that from experience ordinary prison officials could regulate the system of punishment to the full powers of endurance of prisoners. Nonetheless, he told the British Association for the Advancement of Science that:

the time was approaching when the whole subject of prison discipline must be reconsidered, and when a conclusion may be arrived at as to the propriety of continuing a system which, when practised, occasions a vast waste of the vital powers of the prisoners, and vast expenditure of money to provide a dietary, which, although scarcely sufficient, is far beyond that provided for the poor in workhouses, and beyond that obtained by the working classes in general. Steps should be taken to secure uniformity in discipline; and the mode of carrying out sentences should be proportioned to the crime. This might be done in the dietary, and yet allow of such varieties of food as might be found relatively economical in different parts of the kingdom. Instruments may be kept in proper order, and care be taken that the speed at which they are worked shall be uniform; the amount of a day's work would thus be the same throughout the kingdom, and the surgeon must decide as to the fitness of a particular person to perform the required task. A committee of scientific men, properly authorised by the Government, would find no difficulty in placing all this upon a proper basis (106).

Under the banner of medical science, then, the quantification of punishment via experimentation in dietary provision and work-load

allowed doctors to articulate their views and make interventions into the increasingly intense debate about the nature of the prison regime. As I shall indicate, that concern was to reach its apotheosis with the draconian recommendations of the Carnarvon Committee in 1863. For the moment it is important to note that this scientific discourse, its methodology and its theoretical underpinnings was not only based on scanty knowledge of human physiology but was also trapped inside an ideology that saw prisons as places of punishment. This punitive thrust, the will to discipline, could have severe consequences for individual prisoners.

In 1854, The Lancet discussed the death of Edward Andrews, a fifteen year old boy who had died in April of that year in Birmingham prison. Andrews had been imprisoned for stealing four pounds of beef and was placed on the crank which he was to turn 10,000 times every day. This was divided into a number of periods: two thousand turns before breakfast, four thousand between breakfast and dinner and four thousand between dinner and supper. If the task was incomplete, he was placed on bread and water while the shortcomings had to be made up. Additionally, he was not permitted to go to bed until 1½ hours after the other prisoners. Consequently, the boy hanged himself. Two other prisoners attempted suicide at the same time. While the Coroner's jury returned a verdict of "suicide in a state of insanity", the government established a Commission which found that:

the late governor, Lieutenant Austin, and the surgeon, Mr Blount, guilty of acts not only illegal but grossly cruel. As these two men are about to be publicly prosecuted, we shall forbear, for the present, making

further remarks upon their conduct. We cannot help expressing our surprise, however, that no explanation seems, as yet, to have been demanded from Mr Perry, the Medical Inspector of Prisons. Was it this gentleman's duty to discover and prevent abuses in the Birmingham Gaol, or is this prison exempt from his supervision? The occurrences to which we have alluded did not take place in a day; on the contrary, they were spread over some length of time. Moreover, if we remember rightly, similar illegal practices were discovered to be taking place at one other prison at least (107).

The Commission noted that to achieve the task set on the crank, a boy would have to exert a force equal to "one fourth of the ordinary work of a draught horse" (108). The members found prisoners were controlled by leather collars or stocks:

They were of various sizes, but those which appeared to have been most commonly used, were about  $3\frac{1}{2}$  inches deep at the deepest part in front, somewhat more than thirteen inches long, and rather less than a quarter of an inch thick, made of leather perfectly rigid. The mode of use of the collar consisted in the prisoner being first muffled in the strait jacket, having his arms tied together on his breast, the leather stocks fastened tightly round his neck, and being, moreover (where the punishment was inflicted by day), in almost every case strapped to the wall of his cell, in a standing position, by means of strong leather straps passed round the upper parts of the arms, and fastened to staples or hooks in the wall, so tightly as to draw back the arms into and keep them in a constrained and necessarily painful position, at the same time compressing them. It was obvious that such a mode of restraint must necessarily, if continued for several hours, be productive of great pain, - in truth it must be an engine of positive torture. So strapped to the wall, prisoners - chiefly boys - were kept for periods of four, five and six hours, and in some instances for a whole day, by way of punishment for the non performance of the crank labour, and for other prison offences, frequently of a very trivial character (109).

Prisoners were also drenched in cold water. The Commission criticised the prison surgeon, Dr Blount, for defending the practice on medical grounds:

he was, with some difficulty, brought to admit that in his judgment the man had no disease whatever, and that the water was in truth thrown over him solely by way of punishment for his supposed obstinacy and his filthiness. He saved the Commission the duty of giving him the sack by resigning (110).

Blount had also been involved in restraining difficult prisoners. In its review of the case The Lancet described how the prison officials had to deal with a "very refractory, violent and dangerous" prisoner named Hunt. He had been put in a strait-jacket and when this failed:

it occurred to Mr Blount that pressing some salt, which lay at hand ..... into the prisoner's mouth might help to tranquilize him (111).

The journal defended the doctor as a "gentleman of integrity, of Christian feelings (and) of high professional attainments" (112).

The Lancet's ambiguity was reflected in the more general debate and discussion about the role of medicine in prisons. That ambiguity revolved around the role of the medical workers as both caring and being sensitive to the wider concerns of the society. John Davies, the surgeon at Hertford County Gaol wrote in May 1843 that the power of the surgeon was:

very great under the laws and regulations of prisons and the public have a right to expect that he will use it in such a manner as will best secure the health of the prisoners, without, at the same time losing sight of the interests of those who have to support these prisoners (113).

For some doctors, the impact of imprisonment itself was an important

consideration when analysing the ill-health or indeed the deaths of prisoners. Thus in 1845, William Baly the physician at Millbank and a lecturer in forensic medicine at St Bartholomew's Hospital, published a 159 page document in the Medico-Chirurgical Transactions. It was on "mortality in prisons". The document was a tightly argued, statistically based analysis of prison deaths and concluded that "the high rate of mortality which prisoners suffer is really the effect of their punishment and is not owing to the unhealthiness of the class whence criminals are, for the most part, derived" (114). Baly produced a number of papers in which he elaborated this theme. He was concerned to pinpoint particular diseases and to show their impact on prisoners, rather than discussing disease in general. Thus he discussed cholera, fever, dysentery and inflammation, as distinct entities which contributed to, and caused the deaths of, prisoners in Millbank. In his report on the prison, written in April 1850, Baly outlined the impact of cholera on the imprisoned. He described those causes which could be excluded in making the prison liable to "this severe visitation" (115). These included:

low diet, want of cleanliness and bad sewerage within the prison. The diet of the prisoners, which was before abundant, was improved during the prevalence of the epidemic by the addition of half a pint of good porter to the daily rations of each prisoner. The sewerage of the prison is excellent, and at no period was there perceptible any bad smell from foul air arising within the prison. The causes which had, I believe, the principal share in favouring the spread of cholera within the prison were the three following: Its site, its construction and the predisposition of prisoners to disease, arising from the depressed state of mental and bodily health, produced in them by confinement (116).

Baly also felt that the mortality rate from tubercular diseases was affected by a number of factors including deficient ventila-

tion, the cold, want of bodily exercise, a listless and dejected state of mind and the poorness of the diet. In his view:

the diet of prisons, though often perhaps more abundant than the agricultural labourer usually enjoys, yet has generally been less stimulating and also less nutritious than seems to be requisite for the health under conditions so unnatural and depressing as are those almost necessarily attendant on the state of imprisonment (117).

He was quick to point out that the facts he had gathered were "not intended to authorise, and indeed do not justify, any sweeping condemnation of imprisonment as a system of secondary punishment" (118). Baly concluded that improvements in food, heating and ventilation would contribute to the decline in the death rate.

Other M.O.s also raised questions about the impact of confinement. R.J. Dean, the surgeon at Knutsford House of Correction expressed his views to the visiting magistrates in April 1843 that it was impossible to:

keep men under long sentences of imprisonment in robust health, it is not that they actually fall sick, but that they become pallid, care-worn and enfeebled, and lose all their energy and exertion. This is not the effect of the diet, or the labour, the locality or discipline of the gaol but arises I believe solely from their being in confinement and the depressing circumstances attending that confinement(119).

The M.O. at Portland, according to the governor's journal, objected to prisoners being placed on a reduced diet for punishment. But caught up in the system of discipline that prevailed, this recommendation could be rejected. As the governor noted:

The medical officer stated to me that he disapproved of punishing prisoners by reducing their diet but as he declined certifying that such punishment would do any injury to this prisoner, and as it seemed a suitable punishment for an idle man, I resolved in applying it in this instance. It appears to me that if this means of enforcing discipline was prohibited it would be impossible to manage the prisoners, as simple close confinement without short diet would be disregarded by most of the prisoners as a punishment (120).

Until the mid-nineteenth century then, prison medical workers did not speak with one voice when it came to pinpointing the cause of disease and death in the prisons. This was partly a reflection of the localised nature of the prison system itself, the introduction of the Prison Inspectorate following the 1835 Select Committee's report had done little to bring the various prisons under any kind of uniform control or to bring the doctors and surgeons closer together as a professional group (121). It was also a reflection of the paucity of knowledge within the profession itself as to the cause of disease and the lack of systematic research into the relationship between the environment, the body and the mind. This lack of standardization allowed medical personnel a definite space to articulate diverse views. That space was however limited and was to become narrower in the second half of the century as the doctors increasingly articulated their views as a professional group of state servants rather than as individual M.O.s or surgeons. At the same time, the state increasingly intervened to regulate and rationalise, to put the prisons on a much firmer and uniform foundation. What linked the state and the doctors were the ideologies of discipline and management. These ideologies, as I have indicated, had been a central feature of prison medical practice since the late eighteenth century. In that sense, the increasing interventions made by the Victorian state, the directives issued



and that state's concern with discipline, regulation and control struck a medical chord with prison doctors and surgeons. Once more, it was the confined who were to feel the full impact of the developing relationship between the state and medicine in the second half of the century.

Tightening the Penal Screw: Medicine and Discipline 1850-1865.

From the point of view of the prisoners life in the mid-Victorian penal system was hard, uncompromising and unpleasant. So too was death. There were a number of books published in the mid-to-late nineteenth century which detailed the lives of and the circumstances in the deaths of individual prisoners. As Philip Priestley has pointed out "there was no shortage of men in prison who when they heard of any sudden death in the hospital were ready to swear 'his light has been put out by the doctor'". The autobiography of the anonymous 'One Who Has Tried Them [the prisons]' described the details of the death of a prisoner who:

complained that he was subject to heart complaint; but the doctor and Old Bob (the hospital warder) had got it into their heads that he was shamming and the former certified him fit for first class labour. It was very hot summer weather; the man was placed upon the wheel, and used to puff and blow and exhibit signs of intense distress while at work; but this was looked upon as a dodge, and no notice was taken of it, and the man continued at wheel work. A few nights later the warder, going round to lock up cell-doors at bedtime, heard a strange gurgling noise in this man's cell, and looking in, saw him stretched upon his bed gasping for breath .... There was the usual inquest on the body, and the doctor stated the man had died from heart complaint, and the verdict was of course 'Death from natural causes' (122).

As in life, the body of the dead prisoner was not free of the stigma of imprisonment. The soul's escape was not reflected in the body's release from the pain of confinement. 'One Who Has Endured It' gave a moving but chilling account of the Victorian state's ability to regiment and humiliate the body of the deceased:

to die a convict, to be buried in an unknown, uncared-for grave, thrust into a prison coffin filled up with dirty sawdust, as I have seen them done at Dartmoor, so that the ragged old shirt given out to do duty for a shroud may be saved for other purposes, is but a sorry end for a man who has once lived, respected and beloved (123).

The Deaths and Inquests Register for the years 1848-63 lends support to the prisoner's claim. In this period 421 prisoners died in custody. The disposal of the bodies is illustrated below:

Table 9 (124)

---

<u>Institution</u>	<u>Number (%)</u>
Prison Cemetery	147 (35%)
School of Anatomy	102 (24%)
Victoria Park Cemetery	137 (33%)
Family/Friends	19 (5%)
Not listed	18 (4%)

---

The authorities in the majority of cases still laid claim to the body of the prisoner. Breaking the bond of incarceration was, for many, even in death impossible. The penal ties bound their bodies to their gaolers for eternity.

Philip Priestley's history of mid-Victorian prisons brings together a number of accounts by prisoners about the sick and dying. As I shall illustrate below, this was in the general context of a tightening up of discipline and regulation inside. The anonymous accounts of 'A Merchant' and 'Ticket-of-Leave-Man' about sickness and death were supported by Michael Davitt who described how he noticed one prisoner who:

fell out several times to see the doctor, and he was never admitted to the infirmary to my knowledge. One morning I observed him drop dead on the parade, and I believe it was from heart disease, or from bursting a blood-vessel or something of that sort. I think that when he was examined by the doctors, if they had had sufficient knowledge to have detected his disease, they would have admitted him to the infirmary (125).

For Priestley, mid-Victorian prison medicine, despite the humanity shown by some doctors, was nonetheless increasingly being compromised by its:

appointment to fundamentally disciplinary tasks. The doctors patrolled the narrow straits that separate hunger from starvation and punishment from outright cruelty, hauling aboard the life raft of their dispensations this drowning soul or that, and repelling, with brute force if necessary, the efforts of the others to climb to safety. In so doing, they lent to the work of preserving their employers' reputations whatever dignity and authority their emerging profession possessed - and lost it. What these scenes do do is to reveal the suppressed humanity of the prisoners in acts that shine forth - like the unexpected forget-me-nots on the yards at Pentonville - as small beacons of affection and hope in a dark and hopeless world (126).

Prison medical personnel were working in a system that was disciplinary in its orientation. The issues around punishment and regulation crystallised in the early 1860s with the appointment

of two Committees of Inquiry into the prisons. The first was a Royal Commission on the Penal Servitude Acts, established at the end of 1862. The Commission was formed after mounting concern over a series of robberies in London, although how much of this moral panic was generated by the media is a matter of historical dispute (127). The Commission, in response to this panic, recommended a harsher more uniform prison regime. When the Penal Servitude Bill was passed in July 1864, the new measures it contained were indeed harsh including lengthening the minimum sentence of penal servitude to five years for first offenders and to seven years for any subsequent offence. The Act also considerably increased the amount of state intervention and surveillance over ticket of leave prisoners with the use of photography which "was to be employed as an aid to tracing second offenders" (128).

The second Committee that had been established was chaired by Lord Carnarvon. It was a Select Committee of the House of Lords and was to inquire into gaol discipline. The Committee recommended stricter uniformity in local prisons which was to be imposed by an Act of Parliament. Additionally, it also recommended a more punitive regime in the prisons. There was, as Carnarvon, himself, told the House of Lords in February 1863 "an insufficiency of penal discipline" (129) He made particular reference to dietary provision:

.... in a large number of prisons meat was given to the prisoners every day of the week, either in solid form or as a soup. This was a serious question; but when they examined the subject a little further they would find that in many cases there were certain luxuries, certain comforts coupled with what might be called the more ordinary dietary which made it a

very grave question whether the dietary generally given to prisoners was not in excess of what it ought to be (130).

During the course of its meetings, the Committee heard, from amongst others, Herbert Voules, who was the Inspector of Prisons for the Northern and Midland districts. He had 72 prisons under his jurisdiction. Voule's account of how he saw the role of prison diet once more brings out the ongoing concern with quantifying to the nearest micro-ounce a just measure of pain without compromising discipline:

Chairman. Are you of opinion that in dismissing a prisoner from his confinement you are bound to send him out in the best possible physical condition of health, or in that state of health in which he entered the prison?

I think that it is our interest, as well as our duty, to send a man out physically able if he is so disposed to earn an honest livelihood.

Therefore you would endeavour by means of diet to improve his constitution and his physical powers to the utmost?

I would not leave it to the prisoner to say, "I was so reduced when I came out of prison that I was physically incapable of earning an honest livelihood."

Would it be the duty of the governor and the surgeon, in your opinion, to improve that man's physical energies and powers to the highest point?

I would not say to the highest point; I think that no indulgence should be allowed but simply what is necessary to maintain a man in health so that he can earn his livelihood when he goes out. I would forbid any indulgence; and would make the diet as simple as possible, giving the required nourishment.

Are you of opinion that, in your district, there are any indulgences in the matter of diet?

No, I do not think there are.

You do not believe that the dietary in any prison under your inspection contains what may be termed indulgencies?

So far as I can speak from my knowledge at present, if I had observed anything of that sort in my inspection, I should certainly have called attention to it (131).

The Committee was not prepared to make a positive recommendation with regard to reducing the diet of the prisoners. Instead the members recommended that "experiments might be conducted in order to ascertain what might safely be done in this regard" (132).

In 1864, a Departmental Committee was set up whose chair was Dr William Guy, the medical superintendent of Millbank prison. He was assisted by Dr Maitland of the Gosport Military Prison and Dr Clarke of Dartmoor. Guy himself was to become an important figure in the tortured debates around prison diets in the 1860s and beyond. As medical superintendent at Millbank his evidence to the Carnarvon Committee was heard with respect. He had been writing and lecturing on the subject of the social role of medicine since the early 1840s. His work reveals the concern that he had not only with exploring the nature of disease and illness, but also relating this to wider questions of order, control and discipline in society. In October 1842, he delivered a lecture at the opening of the medical session in which he outlined the diseases that were "raging through the length and breadth of the land" (133). He discussed these diseases in relation to the moral degradation, filth and corruption which was prevalent. More fundamentally, he argued that if poverty and disease were not tackled then the social order itself would be overthrown:

.... if we remain deaf to the loud cry of suffering poverty, then shall poverty itself, by the very law of nature, become its own avenger; for the offspring of those condemned to all this complicated misery shall become a moral plague; the old and the middle-aged, who have lived long enough to love peace, and to know the value of delusive promises, who give stability to society and strength to governments, shall cease from among our labouring population and be replaced by the young, the inexperienced, the turbulent and the disaffected. These things, too, are matters if not of demonstration, at least of the strongest inference (134).

In 1844 he presented a paper to the Statistical Society of London. Once more he saw an important link between ill-health, and the condition of the poor. He felt that the "fearful waste of human life" amongst the labouring poor, after "making a liberal allowance for the effects of intemperance and the occasional use of scanty or unwholesome food" could be put down to the conditions in dwellings and workshops (135).

Guy combined this attitude, with a more basic concern about discipline. In a lecture delivered at Kings College London at the opening of the 1846-7 medical session he outlined what he saw as the basic precepts for good medical education and medical success:

... a system of discipline combining college residence, daily religious observances, a regular attendance in the College hall, an early closing of the College gates, a well organized plan of surveillance and authority to check and punish all offences against good manners and the rules of morality - a system, in fact modelled upon but not following too closely, that established in our old English universities, and which, whatever its defects, has the sanction of experience and the stamp of success (136).

In July 1848 he delivered a lecture on the evils of night work and long hours of labour. Once again, he showed his awareness of the conditions in which the working class laboured and the long hours that had to be worked for meagre pay. At the same time he told the audience that:

I am myself a free-trader; I am convinced that it is not just to protect one body of Englishmen at the expense of another, I am convinced that it is not expedient to protect Englishmen as against foreigners; I am a friend to free competition

between man and man, between manufacturers, between merchants, between labourers, between bakers, between men in the same class and the same rank in life ..... For capital so long as it is used in subordination to the golden rule of conduct, is entitled to freedom, protection and encouragement. It is only when it infringes some higher form of property, such as health, bodily and mental, that interference becomes not allowable merely, but imperative (137).

He tried to walk the delicate line between what he saw as supporting the free market economy while simultaneously criticising what he called "the worship of Mammon" (138).

In his evidence to the Carnarvon Committee, Guy warned against "tampering with the dietary" (139). Nonetheless, his own Committee of Inquiry gave "cautious approval" to a "limited reduction in the separate prisons' dietaries" (140). The three medical men also argued that they would not be responsible for advocating the kind of reduction that was made at Millbank in 1822 and Wakefield in 1849 and 1862 that resulted in a serious outbreak of disease. While they criticised the monotony of the diet in the public works prisons they found the monotony in the diet of the penal class "acceptable and suggested that there might be some reduction in quantity to make it even less attractive" (141).

In a paper in the Journal of the Statistical Society in September 1863, Guy himself was very clear about the implications of the high level of the prison diet and the need for change. He made a number of relevant points in the concluding part of his paper:

That the existing prison dietaries present many curious anomalies very difficult of explanation, except on the supposition that additions made for



temporary reasons, such as a wish to satisfy the importunities of prisoners, or a transitory departure from health or outbreak of disease in a small section of the prisoners, have become permanent through inadvertence, or from an aversion to change.

That the dietaries of our county prisons, for periods exceeding four months, and all the dietaries of our convict establishments, are greatly in excess of the dietaries of able-bodied paupers, and probably in excess of the requirements of the prisoners themselves.

That our prison dietaries have been framed under the influence of an exaggerated estimate of the depressing effect of imprisonment, and of an opinion, probably ill-founded, that the physical effect of such depression can be counteracted by increased supplies of food.

That our prison dietaries have also been framed under the influence of a timid feeling, originating in misconceptions as to the true cause of the epidemic of Millbank Prison, but especially in the belief that it was due to a reduction in the quantity of food.

That some reduction in the dietaries of our convict establishments might be made with safety and economy, and that further reductions would probably be justified by well-devised experiments (142).

The three doctors attempted a scientific analysis of prison diet. They conducted experiments with the prisoners, this time at Wakefield prison. The results were not convincing. The M.O. at the prison complained that the dietary experiment had resulted in the "failure of the health and strength of the prisoners, the greater loss of weight, and the greater mortality" (143). Nevertheless, as I indicated above, they recommended a change in the diet, removing meat and cocoa from the diet of the local prisons. Philip Priestley argues that these changes had little to do with science but with more nebulous concepts such as the "experience" of the doctor and a:

healthy, old-fashioned kind of moralizing and one, moreover, that harmonizes nicely with Carnarvon's own conclusion that 'The low animal natures of too

many of the criminal class, and the admitted efficiency of reductions in prison food in cases of prison offences, renders plain the value of diet as one form of penal correction' (144).

Guy's attempt to reconcile discipline and nutrition continued into the next decade. When there was discussion over the introduction of wholemeal bread in 1877, he forwarded a deposition to the Home Office which argued that such a plan was important not only because of the nutritiousness and wholesomeness of the bread but also because the work of grinding meal by hand-mills was to be recommended on several obvious grounds. These included the fact that the work could be carried on in the prison cells and its amount could be easily measured, that it was quite free from danger, it was highly remunerative and "being monotonous and requiring no instruction, it constitutes a good form of punishment", (145).

Not everyone, however, was convinced about the new dietary scale. In a paper delivered to a special meeting of the health section of the Society for the Promotion of Social Science in July 1864, Dr Edward Smith criticised Guy's Committee for basing its report on the replies of "visiting justices to queries which had been forwarded to them through the Home Office and not in any part whatsoever upon experimental researches, as was recommended by the House of Lords' Committee" (146). Smith contended that the proposed scheme had been constructed without any "scientific proof", that the Committee had ignored the chemical composition of food and:

that the results were so erroneous that the low diets

had been made lower, and the high diets higher in nutriment, whilst the Committee believed that they had made the low diets higher and the high diets lower! (147).

In the discussion that followed Smith's paper a number of Medical Officers from prisons concurred with his views and at the "utter failure of the inquiry undertaken by Dr Guy" (148). They called for a new inquiry and for a commission of "scientific men" to be established for such events (149). Dr Foster, the surgeon at Huntingdon prison, had expressed similar views in July 1863, arguing against a reduction in the diet and pointing out that as the influence of the prison was depressing and lowered the "assimilative powers of the body" food and drink should be:

rather in excess of what would be required under other circumstances. The food should be presented in a digestible form; but everything that merely pleases the palate should be avoided. Monotony, on the other hand, inasmuch as it impairs digestion and assimilation, should be shunned. Lastly, the material should be as cheap as possible, consistently with other requirements (150).

Medical voices from other parts of the country also intervened. The surgeon to the general prison at Perth in Scotland argued that the diets in England's county and borough prisons were so low "as to be considered punitive and unfit to sustain health" (151), although that prison had its own problems with an outbreak of Asiatic cholera in July and October 1866. Prisoners in Irish gaols fared even worse than their English counterparts, their diets being pitched at a lower level in terms of nutritional value. Again medical personnel had been involved, first in 1849 when the government was told that prison food was "so much better

than that which the lower classes were accustomed to receive, either within or without the workhouses, that offences were committed for the mere purpose of obtaining food in gaols" (152). The dietary scale was lowered with the sanction of the judiciary and a doctor. In 1854, it was lowered again. By March 1868, it did not include meat at all. Prisoners received two meals every 24 hours which comprised of stirabout or gruel, or bread and milk. Eighteen hours elapsed between the two servings. There were complaints about the quantity of the food and the fact that prisoners frequently fainted but as the BMJ concluded:

The prisoners are well lodged, clad, and cared for; their food is somewhat scanty, but not very seriously so. The consequence of this able report will be to provide all that justice and wisdom can allow to prisoners, in a population where the dietary is generally very far from luxurious, and amongst whom any excess of liberality in the prison scale has been repeatedly found to act as an efficient inducement to crime (153).

The diet was again directly linked to a number of deaths in custody. The Howard Association published a pamphlet in April 1868 calling attention to recent inquests on those who had died in prison or shortly after their release apparently because of lack of food. The Lancet made a similar point in the same month when it described the case of eighteen year old Edward Barrett who had died in Coldbath Fields prison. It was said that he went to prison in robust health, but when released he could hardly walk. A lodging-house keeper told the inquest that his was not the only case that she knew of but that convicts came out, after a few weeks in confinement "reduced to shadows and shorn of their strength" (154):

In corroboration of this statement, another witness deposed that he had been imprisoned in Coldbath Fields for two months; that he was in robust health when he went in, but that on two occasions the treadmill made him very ill, in consequence of which he was put upon two days' bread and water each time; and when he was at length released he was so weak he could hardly walk, and had since been under hospital treatment for palpitation and dyspnoea. The penance of the treadmill begins at 6.30A.M. and lasts till 8A.M. when there is a short interval for breakfast, which consists of one pint of gruel and six ounces of bread. When this is over, the treadmill is resumed till dinner; when the prisoners get, on Mondays, Thursdays, and Fridays, one pint of gruel and six ounces of bread, varied on Tuesdays and Saturdays by eight ounces of potatoes, four of meat, and six of bread; and on Sundays by one pint of soup and six ounces of bread. At 5P.M. the work of the mill ceases, and the prisoners then get half-a-pint of gruel and six ounces of bread. The Coroner justly observed that this fare was quite insufficient for the amount of work exacted from the prisoners, not only in quantity, but (we may add) in quality, the due proportion of tissue-forming constituents being hardly represented at all on three days of the week, and totally absent on the other four. It also appears that the medical examination of a complaining prisoner is of the most perfunctory kind. Not only is no convict's health inquired into on his coming in, even though, as appeared in Barrett's case, he be suffering from pulmonary tuberculosis, but, when the labour of the mill proves more than he can bear, he is simply "looked at" by the prison surgeon, reported as having "nothing the matter with him" to the warden, by whom, in turn, he is reported to the governor, who says - "Coming off the wheel without cause. Two days' bread and water" (155).

The number of deaths at Chatham convict prison rose to 11 in 1865 and "a record 14 in 1866" (156). Convicts had been reduced to eating candles to stave off hunger. As a result of the recommendations of a Commission of Inquiry which included the Medical Superintendent of Millbank, a slight increase in the diet was made. This increase, however, was minimal in its impact both in terms of quantity and with regard to the dominant ideology of punishment and repression. It was a penal discipline orientated, in the words of the Directors of Convict Prisons to "unite reformation with repression and teach convicts to hate prison, but hate crime more" (157).

In this situation, then, prison officials, in general, and medical personnel in particular, were not immune to the wider debates about both penal treatment and how to respond to criminality. Prison officials, involved in these debates ultimately sided "with those who cried 'luxury', whilst taking what precautions they could to prevent too much damage being done to the prisoners in their charge" (158). For prison doctors, the prison rules allowed some degree of discretion when it came to altering the diets of the prisoners who could persuade the medicine man that they were sick. The rules particularly allowed the doctors to examine newly admitted prisoners and if they were found unfit the doctor could indicate which diet the prisoner could have. As Philip Priestley concludes:

Two things flowed from this proviso. It allowed the tables and scales to be retained intact, whilst allowing a degree of flexibility in individual cases, at the discretion of the medical officer. But the discretion thus placed in the doctor's hands raised tantalizing visions of food before the eyes of hungry prisoners. It was a discretion that helped swell the ranks of those who went 'sick' each day, and helped as well to turn the practice of medicine in prisons into a battleground between desperate and cunning convicts and suspicious and resentful surgeons (159).

The long editorial in the BMJ in June 1878 brought these themes together. While the writers outlined once more the various elements in the prison diet and the importance of nitrogen in the diet, the bottom line was repressing crime and if the diet was a part of that process then so be it:

The correction of idleness and misconduct during confinement by reduction of food is a very serious matter. The habitual diet ought to be as low as is consistent with health; and we must understand

that, in reducing it, we are administering corporal punishment. The victim will lose flesh and power of resistance as infallibly as he loses leather in a flogging, and he will certainly be put to pain. But let society beware of discarding in too great a hurry survivals of more barbarous states of civilisation, till it is proved that they are not needful safeguards. The reporters are of opinion that, to secure the purpose of punishment for prison-offenders, the plan of reducing the diet to a scale as low as one pound of bread per diem should be continued. The worst of all corporal punishment is, that it cannot be fairly graduated to the offence; for, while three days' bread and water is not too much to act as a deterrent to very moderate offenders, to continue its infliction over that time results in injury beyond what is designed. It may be suggested, however, that the three days' fast can easily be repeated over and over again after an interval, just as floggings are administered in moderate doses weekly or fortnightly to brutal offenders. Thus the strong moral influence of anticipation is brought into play, whilst danger to health is not incurred. The power of the stomach as an implement of education, moral and intellectual, is the subject of a familiar quotation from an observant poet, and it is a pity to surrender any power left us of improving the manners of criminals (160).

As in the twentieth century prisoners confronted the discipline and regulation of the system. Medical personnel could come in for particular, sometimes fatal attention. In February 1856, The Association Medical Journal recorded the "brutal murder of another Medical Man" (161). Charles William Hope, the assistant surgeon to the Stirling Castle convict hulk at Portsmouth was stabbed in the neck by a convict wielding a razor. The dead man had, according to the journal "refused to certify the necessity for the convict's remaining on the lower deck or invalid ward" (162). The Directors of Convict Prisons described a similar case the following year in their report on Pentonville where one prisoner in particular gave serious cause for alarm when he "opposed himself to the rules and murmured at the dietary, which he asserted was insufficient to maintain his strength" (163). The Directors described how:

he one day preferred a request to be allowed some indulgences in addition to his diet, and when this was refused as unreasonable he savagely attacked the medical officer and stabbed him with a weapon he had previously constructed for the purpose, which he had kept concealed in his coat sleeve, wounding also two of the warders who came to the rescue. When spoken to shortly afterwards on the serious nature of his offence, he expressed no contrition, but, on the contrary regretted that he had not 'killed the doctor' as he had intended, alleging that for some time past his food had been 'powdered' or poisoned by the medical officer's orders (164).

Such events were underpinned by other, more common forms of rebellion such as assaults against prison property. This included tearing clothes, smashing windows and the destruction of bedding (165). Women, in particular, expressed their feelings in this manner. According to the prison visitor Felicia Mary Skene this behaviour had a "distinct rationale of its own, illogical enough, no doubt, but a well-considered method in the apparent madness. The object of it is simply one of deliberate revenge for the pains and penalties to which their imprisonment subjects them" (166). The accounts of prisoners themselves testified to the rationality in their behaviour and the understanding that they had in terms of their motivation. As one commented:

They have treated me like a beast and I have become one ..... I did it for variety. Oh, the monotony of prison life! I had to smash the glass of the cell and glass everywhere I could or I should have gone mad (167).

Such behaviour could result in a further round of disciplinary activity directed at controlling the prisoner. The body was the prime focus of attention as the authorities utilised a number of techniques designed to pacify and debilitate those who had been



responsible for the destruction of the state's property. Through this destruction the body forfeited further its rights to be treated with dignity. Shackles, handcuffs, manacles, chains and physical violence were powerful manifestations of the state's attempt to bring the physique of the refractory confined into its own orbit of strict discipline. There was a particular technique of discipline reserved for women. This was called hobbling and consisted "in binding the wrists and ankles of the prisoner and strapping them together behind her back." The hobbles were:

Strong leather straps and wood appliances which fasten the leg and foot back behind the knees to the thigh, the arms being fastened down so that the hands could not be raised to the mouth, and the unhappy individual in the hobbles had only her knees to rest upon, and with her back to the wall had to be fed like a baby (168).

Finally, for those who could not, or indeed would not, be controlled by such means, the strait-jacket was used.

In October 1866, the BMJ described how the latest report from the prison inspectors indicated that the practice of gagging women prisoners in Manchester gaol was directed at those "who have persisted in disturbing the prison by shouting and screaming. This is a mode of punishment unknown to the law" (169). In March 1868, the same journal carried a long letter expressing the writer's horror not only at the practice but also at the general direction in which the punishment of offenders was moving:

Sir, - The paragraph in your recent number relating to the practice of "gagging" in the navy, reminds

me, that, between two and three months since, a paragraph went the round of the papers, without contradiction, the purport of which was as follows:- "That the 'breakings out' of female prisoners had always been a source of perplexity to the authorities, who had tried 'solitary confinement', 'the dark', etc., without effect; but that a system of 'gagging' had lately been adopted which had proved quite effectual."

If it be an actual fact that these poor hysterical creatures have been thus treated, it is a most lamentable instance of barbarity. Any man of sense - whether in the medical profession or not - who knows anything of the nature of women, must readily understand that, under a system of close confinement, with no object in their existence, they are likely to become feverishly irritable, and that this irritation, may relieve itself in what are known as 'breakings out'. In fact, 'breakings out' may be looked for as one of the natural results of the system at present in force. The best woman alive might become hysterical or violent if subjected to prison discipline. What can be more cruel than to adopt such measures as confinement in a dark cell, gagging, etc., with these poor creatures?

The sentences given of late have been terribly severe. I know of an instance in which a lady was sentenced to five years' penal servitude for stealing a shawl (first conviction); and one, of a poor starving woman, sentenced to seven years for stealing a purse (second conviction); and there are many similar. If, therefore, these terrible sentences are to be endured (often for comparatively trivial offences), it is most important that the medical profession (which has done more for the good of mankind than any other profession or calling) should satisfy itself that no barbarism is permitted.

For myself, I object altogether to long sentences. I think they are a mistake, in every respect; that they make "gaol-birds"; that they cause the prisoner to lose all hold upon the outer world; that they are demoralising to the prisoner, and expensive to the nation, and that they are quite unnecessary in our present state of civilisation. The question at present before us is: How was it that this paragraph about gagging in female prisons went the round of the press unchallenged? Was it because it was true? I am, etc., S.K. (170).

Order was fragile in other prisons too and could be restored often with brutal force. There was a mutiny at Chatham public works prison in 1861 and another in Portland in 1864, during which the ringleaders were fired on by the civil guard. In Millbank in 1863,

prisoners were given corporal punishment on 34 occasions. All but one of the prisoners recieved lashes with a cat, while another was given 12 lashes with a birch for writing and making drawings in his Bible. Most of the other offences were for destroying prison property such as blankets, rugs, jackets, glass, bibles and prayer books:

For these offences the prisoners usually received either 24 or 36 lashes with the cat. Other offences included using threatening, abusive or disgusting language towards governors, chaplains, doctors or warders. For these the punishments were the same as above (171).

A similar picture emerged at Dartmoor where during 1863, 880 punishments were awarded including 504 for insolence, disobedience and threatening language, 204 for disrespect and disorderly conduct, 16 for assaults and 15 for escapes (172). The chaplain at Millbank summed up the basis of discipline in these prisons when he pointed out in his annual report that:

No discipline can succeed, which fails to impress the prisoner with the power and determination of those who administer it to enforce obedience, if it be necessary to resort to such means (173).

#### Individualisation and the Consolidation of Medical Power.

Discipline was thus a cornerstone of the prison system in the mid-1860s. At the same time this period also saw the beginning of a line of medical reasoning based around the examination of the mind and the subjugation to the medical gaze of a range of social

problems from alcoholism, through to feeble-mindedness and moral degeneracy. This development took place in the context of the gradual consolidation of science as the dominant paradigm for explaining the natural world. Scientific explanations of the social world were a natural and logical extension of this consolidation. Medical science was pivotal in this process. According to Roger Smith this medicalisation refers to the way in which:

events previously the subject of moral judgement have become the object of medical practice. This change is usually linked to a sociology of professional medical interests, though it should also be correlated with secularisation, scientific naturalism and the rise of the social sciences (174).

A number of writers have pointed to the inherent conservatism and authoritarianism of these changes. The development of physiology in the early nineteenth century, according to Roger Cooter, encompassed not only the building of scientific knowledge but also worked as ideology in that:

the organismic metaphor functioned in a diversionary rather than an explicitly negative manner. Thus, instead of looking to the conditions they had in common the recipients of the knowledge were inclined to focus on the interdependence of specialized parts in natural systems and hence to strive to fulfill their unique individual capacities (175).

Lesley Doyal and Imogen Pennell have also pointed to the way in which science became "the metaphor within which the existing social and sexual division of labour was justified and reinforced" (176). Darwinism, in particular, both rationalised competitive and individualistic struggle and at the same time used "scientific and

especially biological concepts for explaining and justifying particular forms of social and economic relationships" (177). This point has been developed by Steven Rose et al in tracing the emergence and consolidation of biological explanations of the social world. These explanations, within which criminology developed in the late nineteenth century, emphasised the quantification of behaviour, so that it could be "distributed in relationship to a norm ...." (178). That norm was very much tied up with notions of the natural order, the proper relationship between rich and poor, scientifically and medically legitimated. As Rose et al point out:

Darwinism wrested God's final hold on human affairs from his now powerless hands and relegated the deity to, at the best, some dim primordial principle whose will no longer determined human action. The consequence was to change finally the form of the legitimating ideology of bourgeois society. No longer able to rely upon the myth of a deity who had made all things bright and beautiful and assigned each to his or her estate - the rich ruler in the castle or the poor peasant at the gate - the dominant class dethroned God and replaced him with science. The social order was still to be seen as fixed by forces outside humanity, but now these forces were natural rather than deistic. If anything, this new legitimator of the social order was more formidable than the one it replaced. It has, of course, been with us ever since (179).

Roberta McGrath makes a similar point indicating how medical power and the ideologies that flowed from it was tied into new forms of hegemonic control in the late nineteenth century. Powerful medical metaphors that were mobilised such as 'moral leprosy' and the 'degeneracy of the species':

reflected the fear of the bourgeois class. It would either maintain its rule or quite literally go under, hence the need to mobilise new institutions and new

ideologies ... The repressive apparatuses (police, army) are merely the outer wall of the state's power. This allows us to make sense of the new alliance between state, law and medicine. If the mechanisms of power had shifted it was because control could not be exercised too violently nor too spasmodically for fear of resistance and disobedience. It is precisely for these reasons that 'medical control' increasingly replaced legal mechanisms (180).

Within the prison system this discourse increasingly came to prevail. As David Garland explains, psychological and medical science underpinned systems of classification allied to individualisation:

From the point of view of this new system, there no longer exists a universe of free and equal legal subjects which coincides with the sane adult population. Now there are categories which pose exceptions to the rule, classes which exhibit only limited degrees of freedom and a large population of 'special cases'. Neither reason nor responsibility can any longer be simply presumed in the presence of juveniles, vagrants, habituals, inebriates or the feeble-minded. The modern system's 'recognition' of these diverse populations, and the new 'criminologies' which encouraged this enlightenment and sought to extend it, together prompt the question of 'who are you?' whenever an offender enters their gaze. However, in contrast to the certainties of the past, the answer to this question cannot now be known in advance. Inquiries are necessary, including extra-legal inquiries, and officers are now authorised to continue the investigation beyond the court and to relay back their assessment.

So although the law retains its central place in modern penalty, it is no longer a singular discourse which excludes all others. The new system accords a place to the judgement of non-judicial personnel, such as probation and after-care officers or the Borstal and preventive detention authorities. It invites information and background reports, character judgements or the certification of experts. The findings of the psychological sciences are allowed to enter into circulation, particularly in regard to the category of the 'juvenile-adult' and its treatment in Borstal institutions. Likewise the medical definitions of alcoholism and 'feeble-mindedness' come more and more to prevail in the legal treatment of inebriate and mentally-deficient offenders. There is even a discernible tendency in the regimes at Borstal and elsewhere

to see reformation less as a deliberate choice on the part of offenders and more as a physical or psychological effect of the practices brought to bear upon them (181).

In this universe, then, the increasing confidence and professionalisation of medical practitioners was reflected in their burgeoning influence in late nineteenth century social life. Within the prisons, medical personnel, as I shall indicate were neither unaware of, nor immune to the changing status of their profession, nor to the positive endorsement that medical science was increasingly being given for its interventions into social problems. Those interventions by prison medical personnel, reflected and reinforced the views of their medical brethren in general, particularly on questions around disorder. The threat of disorder was the umbilical cord that linked medical practice and classification to social control both inside and outside the walls of the penitentiary. As Elliott Currie notes, rather than being seen as a humanistic movement:

The conceptions of "defective delinquency", "psychopathy", or "constitutional inferiority" provided a quasi-medical rhetoric that justified the use of the penal system as a means of sifting out and isolating the most expendable and intractable of a generally expendable stratum of the population and that glossed and mystified these essentially political and economic functions with a language of humane "treatment" and "social service" (182).

The years 1865 and 1877 were important moments in the development of modern penology. In 1865 the Prisons Act was passed. It contained 82 clauses and 104 regulations for the government of prisons. Amongst other provisions, prisoners could be removed from one prison to another if a contagious disease broke out.

Furthermore, an infirmary for the sick had to be provided in every prison. The surgeon was instructed to see every prisoner at least once a week. In the local prisons, the role of the M.O. increased, particularly as doctors started to look for, and find, increasing signs of insanity amongst a larger proportion of the prisoners. As Roger Smith points out:

Officials who met the accused before the trial increasingly influenced his or her subsequent history. Prison officers and particularly prison doctors became more sensitized to the possibility of insanity in those temporarily in their custody ..... This [1865] Act regularised prison administration and ensured that the prison surgeon inspected every new arrival, which perhaps increased the chances of finding insanity (183).

Nigel Walker has made a similar point (184). This increase in the doctors' role in judging sanity and insanity was itself bound up with more general medical and criminological developments around the idea of "progressive degeneracy in which ever worsening moral and physical defects could be passed from one generation to another" (185). The psychiatrist Henry Maudsley and the Scottish prison doctor James Thomson proposed that:

there was a class among criminals, of 'born criminals', lacking in intelligence and 'normal instinct' and often with physical deformities, or conditions such as epilepsy or insanity. Thomson's work in particular was supported by statistical observations and family studies drawn from his prison experience, and made quite an impression on his contemporaries (186).

Other prison medical workers expressed similar views. John Campbell, a surgeon who served for thirty years in the convict service talked of the physical degeneracy of criminals when he argued that:



The physiognomy of prisoners as well as the conformation of the skull, is often remarkable; and the result of many post-mortem examinations has proved that the brains of prisoners weigh less than the average, and that a large brain is an exception (187).

These views were supported by writers such as Thomas Carlyle who described prisoners in the following terms:

Miserable distorted blockheads, the generality: ape-faces, imp-faces, angry dog-faces, heavy sullen ox-faces; degraded underfoot perverse creatures, sons of indocility, greedy mutinous darkness, and in one word, of stupidity, which is the general mother of such (188).

Such attitudes were to become increasingly prevalent and institutionalised in the last three decades of the nineteenth century.

The 1865 Act which increased the power of the doctors did so at the expense of more openness. In December 1871, the BMJ complained that medical reports coming from the public works prisons were "confusing and obscure" (189). In 1874, central government reinforced its power still further by denying access to local medical officers of health who wanted to inspect the "grave sanitary defects" that existed within one particular prison (190). The passing of the 1877 Prison Act further reinforced the position of the P.M.O. According to Dr Quinton's autobiography of his life as a P.M.O., detailed physical examinations were introduced on reception and recorded. Similarly, if a prisoner was sent to hospital, his/her history was to be written down. Periodical reports and returns were also established on a regular basis. As he pointed out "it became necessary, therefore, to appoint

to the prison service medical officers who could give all their time to the work in the large prisons" (191). These changes did not quell the controversy around medical standards, medical care and discipline behind the walls. Again the question of diet and discipline was a central part of this controversy. Some of the doctors expressed their views on the subject quite clearly. Quinton, for example, was explicit about the relationship between dietary punishment, discipline and science:

though it always seemed to me a more or less barbarous and senseless proceeding to apply to human beings, was nevertheless very necessary with unruly prisoners. I know of nothing approaching a scientific excuse for its use, except the principle on which a horse has his oats reduced in order to tame his spirit (192).

In a letter to The Lancet in February 1873, Thomas Bogg, the former surgeon of Louth prison supported this position arguing that low diet was "undoubtedly necessary as a punishment for convicted criminals, but it should bear some proportion to the work they perform, and where it does not impaired health inevitably follows" (193).

This attitude towards discipline was underlined in 1878 when the newly appointed Prison Commissioners asked their medical officer Dr Gover, to report on the use of the hated treadmill. His report was enthusiastic and legitimated the erection of "many new machines" (194). Gover himself claimed that the treadmill had the great merit of:

not only being an instrument recognised as the one best adapted for utilising the power of a man, but it is also the only simple machine in which a number of men can be made to work together with a certainty of each man doing his specified share of the work.

It is a machine at which there can be no shirking, notwithstanding what is said about the ease of distinguishing 'old hands' from novices by the mode of moving the feet (195).

This view was not whole heartedly supported by the medical profession. Drs Guy and Hastings wrote to the Home Office arguing that the absolute uniformity in administering the punishment of hard labour (as Gover recommended) was impracticable. Discretion for M.O.s they felt was necessary to pinpoint "the capacity of different prisoners for hard labour. The discretion is already exercised and as far as our experience extends, and in our belief, wisely and conscientiously" (196).

Outside commentators were also more critical about the direction of penal practice. In its editorial comment, The Lancet railed against the 1877 Act arguing that while it had contributed towards greater economy of administration and increased severity towards the prisoners, it had also curtailed the powers of the Visiting Justices to scrutinise what was happening inside. The journal considered that many of the provisions in the Act would debilitate prisoners still further. This included the new prison diet which for men on hard labour was "too severe, and certainly insufficient for their physiological requirements" (197). The writers concluded that while they had no "foolish sentiment towards the criminal classes" nonetheless it was their conviction that the system of prison discipline was "still very defective, and that to many criminals it is most unjust" (198). The journal made similar comments in August 1879, again calling for more openness in the administration of the system and the appointment of a superintending medical officer of high standing "who would have the over-

sight of the medical arrangements in all convict prisons" (199).

The Howard Association also pointed out that prisoners sent to gaols to serve short sentences were having their health destroyed within a few weeks. They were "virtually sentenced to death" (200). William Tallack, the Association's Secretary, argued that this state of affairs was due to the fact that under the new centralised regime the doctors had to fill in an elaborate set of forms and returns and send them to the Home Office. This was to the detriment not only of the prisoners' health but undermined the accountability of the system. In The Lancet's view, centralisation under the 1877 Act had "the effect of preventing that local care, judgement and interest in prisons which was formerly given by the magistracy" (201).

From the perspective of the confined, the finer nuances in the debates about the quantity of punishment and the differences between state servants on the matter, was not something that was obvious to them. Discipline, regulation and control were heavily maintained, sometimes with fatal consequences. The regime was also resisted and defied. In 1888 Dr Barr, the surgeon at Kirkland prison was attacked and stabbed by a black prisoner (202). The next year, the M.O. at Usk was also attacked and knocked unconscious. The guilty prisoner was sentenced to 36 strokes of the cat (203). In his autobiography, Dr Quinton described how prisoners petitioned about medical care to the Home Secretary, how escapes and attempted escapes were "a frequent occurrence" (204) and how criminals would offer "active as well as passive resistance to the most benevolent designs" (205). Prisoners' accounts describe a different reality from that

outlined in the official reports. In a sense, they are similar to the doctors' accounts in that conflict was recognized as part of the prison experience. They differ, however, most clearly in the range of criticisms raised about medical treatment inside. Six Years in the Convict Prisons of England published in 1869 and written by the anonymous 'A Merchant' described spending two years in the hospital ward of Surrey prison. This was due to a disease in his knee which was to result in the amputation of his leg. He described how the two doctors in the prison began their rounds at 9A.M. When they entered the hospital ward, the prisoners were called to attention when:

all the prisoners out of bed stood up, and as the doctors passed, noting down on a ticket the date and remarks on each man's complaint, they were saluted by the patients in the military fashion (206).

After some weeks of suffering his leg did not get better, his knee became so sensitive that anyone passing near his bed caused excessive pain. It was finally removed by having "the flesh cut, and the bone sawn through at the thickest part of the thigh" (207). When recuperating 'A Merchant' reviewed the medical service inside and placed the blame for the standard of care on the malingerers who caused so much of the:

apparent sourness, indifference to, and sometimes cruel neglect, if not positive aggravation of suffering, which I have noticed in the manner and treatment of most of the convict surgeons I have met with (208).

Five Years' Penal Sevitude authored by the anonymous 'One Who Has Endured It' and published in 1877 told a similar story (209). In 1881 the anonymous 'One Who Has Tried Them' published Her Majesty's Prisons: Their Effects and Defects (210). The author catalogued cases of medical abuse and the decline in the health of a number of prisoners. When one prisoner complained about a warder:

the warders put their heads together and determined to make it hot for him. K-----n was now beginning to complain of being ill, and to apply to the doctor for a little extra food, so the warders agreed amongst themselves that whoever went round with the doctor was to take good care that he did not give him anything extra, but whenever K-----n applied they were to persuade the doctor that he was a lazy fellow trying to humbug him by shamming. They were perfectly successful in their scheme, for although K-----n frequently applied to the doctor, the latter would never give him any extra food, and after three or four successive applications sent word to K-----n by the corridor warder that he was not to ask for extra food any more, as he would not give it to him.

It was now December, and K-----n had completed some ten months, of his sentence, and it is a most significant fact, that he was the only man that had passed more than nine months in the prison who had not got extra diet of some kind. Early in January K-----n again sent for the doctor, complaining that he was dreadfully weak and ill, and begged very hard for a little extra food, but to no avail (211).

The prisoner eventually died. The author indicates how the death was handled by the authorities and the close inter-relationship between the Home Office and the prison concerned:

While K-----n's body was awaiting the inquest, a doctor was sent down from the Home Office to examine the prison, and he, I fancy, was rather surprised that K-----n had not been sooner sent to hospital, for some little time after the Xshire doctor got a letter from the prison commissioners, asking why he had not sent K-----n up to hospital sooner. What excuse he made I do not know, but there the matter

ended. A prisoner's chance of getting over a serious illness was pretty small, when one calmly considers the odds against him - a careless doctor (under certain circumstances), a brutal, unscrupulous hospital warder, and a couple of ignorant labourers to act as nurses.

It may perhaps be thought that I have exaggerated this account, but it is not the case, I have, on the contrary, been most careful to keep well within bounds, and am prepared, if necessary, to substantiate from the lips of the officials themselves every word that I have stated above (212).

For those on punishment, the medical consequences could also be extreme. The Irish Fenian Jeremiah O'Donovan Rossa spent four months on punishment diet of bread and water at the end of which his body was covered with "small pustules, like little boils. Not an inch of me was free of them, and they looked very ugly with their white heads" (213). Irish prisoners were particularly subjected to the strict discipline known as the Pentonville system. The prisoners were not allowed to speak to each other, nor, as far as was possible to see each other. Each prisoner had his/her own cell which was 13 feet by 7 feet. The prisoner ate and worked in this cell where:

he is kept for six months at least, cut off, as far as ingenuity can do it, from all communication with his fellow-men. He has to conform minutely to a strict system of rules; if he fails in this he is liable to be flogged or sent - it may be for as much as twenty-eight days - to the "blackhole" upon bread and water ..... That we may know what it is, let us judge it by its fruits. There are in a considerable proportion of cases, suicide, fatuity or madness (214).

The Lancet raised serious questions about treating Fenian prisoners as common criminals. The BMJ highlighted, without supporting, the accusations by Fenian prisoners, that they had been ill-treated,

ill-fed and over-worked and this in particular had contributed to the death of Charles McCarthy in January 1878 (215).

The accounts by prisoners of the deleterious effects of prison discipline werereflected in the ongoing debates in the 1870s and 1880s around deaths in custody and prison mortality rates. Coroners' inquests were very important forums for bringing the power of the institution to account. It was here that the statements of prison managers and M.O.s were often severely challenged. While the medical journals argued that Coroners should be trained in medicine rather than law, it is clear that the juries were sceptical of official accounts. As Dr Quinton commented, the inquests were:

frequently embarrassing, if not annoying, to the prison witnesses, especially medical officers. A fixed idea seemed to possess the minds of jurymen that prisoners were either starved, or done to death under the new management. The examination of witnesses often assumed an aggressive or offensive tone on matters relating to hospital and general treatment, the sufficiency of diets, the use of stimulants, and so on - questions which had not aroused any similar attention when prisoners were being maintained out of the rates ..... popular distrust of the system, judging from press comments, the attitude of jurors and other sources of information, seemed to exist in no uncertain degree. So captious and unreasonable were some juries that an intelligent onlooker remarked that "medical officers were practically tried for man-slaughter at every prison inquest" (216).

While prison doctors could publicly disagree over the precise interpretation of mortality rates, as Drs Rendle and Nicolson did in the columns of the BMJ between April and June 1871 (217), the medical press was increasingly concerned about the fatal effects that the prison diet could have on the confined.



Margaret Girvan's death in Armagh prison in August 1879 was one example given by The Lancet where the inquest jury's verdict that the deceased had died of "hectic fever in a shattered constitution" was supported by a rider that the "very low scale of diet which she received in the prison from the day of her committal had a great deal to do with the result ....." (218).

The previous February, the Commissioners published the report of an inquiry into the death of John Nolan in Coldbath Fields. The prisoner's death caused both the medical and popular press to call for changes in the system of discipline and diet. According to the inquest jury, Nolan died in the prison infirmary from "the mortal effects of acute inflammation of the lungs." Furthermore, his death was:

accelerated by the repeated and excessive punishment of bread-and-water diet, which was ordered by the governor and sanctioned by the surgeon. The jury are of opinion that it is impossible for the medical officer properly or effectually to attend to his duties at the prison without being resident (219).

One member of the jury stated that "he did not believe a word of the doctor's evidence. It was full of contradictions" (220). The doctor defended the discipline of the prison before the Coroner. He provided a detailed account of the prisoner's life inside indicating that he examined between 50 and 60 prisoners each day. When he examined the deceased "he had a slight cold and I kept him in the convalescent ward for two days." His views on the prisoner revolved around the deceased's

ill-discipline, his bed-wetting was put down to laziness; also he considered a cold cell better to sleep in than a warm one.

Prisoners were:

legitimately punished if they do not do their work. I believe the deceased wilfully neglected his work and that it was not inability from weakness. If the deceased had stated that he could not do his work, and had showed sufficient reason, I should have lessened his amount of work (221).

The official inquiry which included William Guy exonerated the surgeon and the governor and did not endorse the opinion of the Coroner's jury "that the duties of the medical officer cannot properly be performed without residence" (222). The surgeon himself argued that the inquest had been unfairly conducted, that public meetings had been held on Clerkenwell Green and in public houses "to influence the jury", that discharged prisoners were admitted "to prompt the coroner with questions" and that he had:

distinctly stated to the coroner and jury ... that I was responsible entirely for all the punishments being carried out and that no prisoner was ever punished without my certifying that he was fit to bear it. I do not in this case believe that the punishment had anything to do with the prisoner's illness and death ... The sudden change in the weather was quite sufficient to account for his illness (223).

The Lancet was less sanguine and argued that the jury's verdict was fully justified by the:

extraordinary facts disclosed by the inquest. It is impossible for the matter to rest here and the question of prison mortality, discipline and diet with special reference to Nolan's case must be brought for

early discussion in the House of Commons (224).

The journal linked a number of deaths in the early 1880s to the passing of the 1877 Act and the low diets inside. In February 1880 it drew attention to a "lamentable series of deaths in Her Majesty's prisons under the working of the new Act" (225). The article defended the prison doctors but chastised the disciplinary orientation of the system, and the Commissioners' defence of it. As with the prison doctors, however, the journal did not condemn the system completely and argued against:

undue leniency towards any criminal class; punishment should be awarded them to the utmost extent of their endurance; but we must protest against a system that barely scathes the strong, but crushes the weak (226).

In July 1880 it talked of the "unparalleled mortality among the short-termed prisoners" pointing to the death of William Grant in Walton gaol, Lancashire (227). Once more, the writers argued that the prisoner's death was due to the:

faulty arrangements of our prison system. A man apparently healthy is passed by the medical officer, after a single examination, as fit either to undergo a period of severe starvation on bread-and-water, or to perform severe mechanical labour. He is then taken charge of by the prison officials, and his punishment commences. If the man becomes ill, he is referred to the medical officer, but there seems no provision made for watching the effect of severe punishment on the various constitutions of prisoners till the effects manifest themselves pathologically (228).

The writers concluded with a call for an increase in medical staff to supervise prisoners who were on bread and water or severe mechanical work such as the treadwheel and argued that:

The prison system has already caused some sensational deaths; but nothing is heard of those prisoners who are discharged with their health hopelessly ruined by the severe and ill-supervised discipline they have been subjected to. A committee of inquiry is urgently called for to settle this question, and we hope the investigation, when undertaken, will be thorough and impartial (229).

In June 1881 it referred to the "severe quality of the diet for short-termed prisoners" (230). In December it commented on the higher death rate amongst women prisoners in comparison to male prisoners. These statistics had been gleaned from the annual report of the Prison Commissioners but the medical inspector did not explain the cause of this disparity within the report. The lack of information in the medical statistics was a particular cause for concern. There was no information on the comparatively high death rate from heart disease, nor about those whose deaths had been described as arising from "natural causes":

The question at once arises, What were these natural causes? for with experience of recent inquests still fresh in our minds, we have considerable misgivings on this point. Even if we do the prison authorities injustice in this matter, still the fact remains that more than half our prison mortality is not fully reported. If medical statistics are published at all, they should be published fully (231).

In January 1882 it writers pointed out that short terms of imprisonment were "destructive to health, and consequently dangerous to life" (232). In April 1882 there was "another prison scandal" at Chester gaol. When James Fry was admitted to the prison he was found to be suffering from bronchial cough and angina pectoris, with disease of the mitral valve. He was not removed to the prison infirmary but confined to his cell. He was not prescribed

medicine, nor was his food increased to any noticeable degree. At the inquest the jury returned a verdict of death by natural causes but considered that his death was accelerated "by the want of a more nutritious and generous diet than that allowed the deceased while in prison; they also blamed the medical officer for not having him treated as a patient in the prison hospital" (233). The journal repeated these allegations two weeks later and called for more comprehensive information to be made available on the health of prisoners in local gaols. Again its writers repeated the view that medical information in the official reports was "utterly valueless for the purpose for which it is wanted, of really getting an insight into the practical working of our prison system .... information respecting the health of the prisoners are as much called for as long statistics relative to brush and mat-making" (234). The BMJ was more defensive of the P.M.S. in particular and the system of discipline in general. In its comments on the Chester case, the journal argued that the M.O. had performed his duties conscientiously and professionally. Furthermore, the cause of death could be blamed on the prisoner himself because he had the power and the habit of accelerating his heart's action which induced cardiac irritability, excitement and fainting. The writers concluded that:

the evidence goes to the effect that he was in the habit of doing this, either to excite pity and obtain stimulants, or as a means of displaying personal irritation. These attacks of sudden faintness which .... he seemed to have the power of bringing on at will, were no doubt extremely injurious to himself, and might obviously at any moment end in death (235).

Two weeks after the editorial a correspondent wrote to the BMJ defending the P.M.S. particularly the role of the doctors in remitting prisoners from hard labour including those "most abandoned criminals, if they be only the lucky possessors of such a trifling defect as a varicose saphena vein" (236). What is interesting about this anonymous correspondent is that his remarks crystalised the views of the medical profession with regard to discipline and the criminal class. For while The Lancet often and the BMJ occasionally criticised the workings of the system they staunchly defended P.M.O.s and the disciplinary direction of the penal system of which those same M.O.s were an integral part. As the writer pointed out:

... in these days there is much maudlin sentiment abroad in reference to criminals and this pervades largely that class from which the coroners' juries are generally drawn. The popular interest, indeed, that attaches to the felon not engaged in his employment is so great, and so vastly superior to that accruing to his colleague in distress, the honest pauper, that prisons are fast becoming more comfortable homes than workhouses, and prisoners generally are likely to have, ere long, a better time of it than the officials charged with their care and keeping (237).

Similar sentiments were expressed around another two deaths late in May 1882. Again they were short-term prisoners whose deaths The Lancet attributed to the harshness of the system within which "the severity of the discipline and the insufficiency of the dietary" were the major factors:

We have recently commented on the unscientific characters of dietaries no. 1 and no. 2 that we need not enter upon that point again but it must be manifest to all who are not blinded by routine that bread and water a plank bed and hard labour

are likely to foster that despondency which is felt most acutely during the first weeks of incarceration. If such severity is to be practised, let it be towards the end of the sentence, when the prisoner has been under the observation of the medical officer for some time (238).

This tension between the recognition that the regime was contributing to untimely deaths and the desire not to be lenient towards the criminal was captured by the contribution of a doctor to the journal the next month. The doctor argued that it was the constitution of the Prison Commissioners itself which was at fault rather than the Prison Act. He argued for the creation of a Medical Commissioner with specially trained inspectorial staff to supervise the 77 prisons in the system. As to the overall disciplinary thrust of the system, this was to remain intact. As he chillingly explained:

It stands to reason that for the protection of society and the welfare of the State lawbreakers must be punished, and the punishment for short sentences must be such as to act as a deterrent on liberation. The country will not tolerate corporal punishment unless in extreme cases, so that the Commissioners can only punish offenders by means of their stomachs in combination with labour and cell discipline; this organ requires delicate manipulation, and the dietary system must be beautifully adjusted to punish the prisoner with hunger, and yet stop short of injuring his health. Hence dietetics and physiology are prominently set forth in prison management (239).

The Lancet agreed with this suggestion in an editorial pointedly called Prison Management. While arguing once more that the published statistics did not present a true picture of prison mortality, the writers thought that the introduction of scientific experts and proper medical inspectorial staff would

alleviate these problems and reduce the death rate. Discipline was not to be replaced but rather what was needed was:

a thorough knowledge of the effects of prison discipline, not on the herd of criminals but on the individual. How do bread-and-water diet, hard labour, and the plank bed affect respectively the robust, sturdy, and well-fed ruffian, and the broken-down, half-starved offender, whose crime in the majority of instances was committed to supply his natural wants? Does the prison system punish both equally? What, again, is the effect of seven days' bread and water, with hard labour, on prisoners with constitutional disorders, either acquired or inherited? Is it right that prisoners should be submitted to such severe treatment when the officials must be in utter ignorance from the man's antecedents whether it can be safely applied? Ought not low fare and hard labour, if they are to be retained as a punishment, to be applied at the end, not at the beginning of the sentence, at a time when the prison officials have got to know something of the prisoner's condition and constitutional peculiarities? (240).

The scientific expert was to be one of the cornerstones of this system. The journal argued that the mental and bodily health of prisoners was entirely a medical question and that any inquiry into the prison system should be composed of such individuals as it was "utterly impossible for any body of laymen, however able, to conduct such an inquiry" (241).

In December 1882 another prisoner died, this time in Huntingdon gaol. There was no M.O. in the prison and no arrangements had been made for emergency cover in the event of a prisoner's sudden illness. The Lancet argued that the fault lay with the Prison Commissioners who were trying to secure medical provision at the least possible expense. They therefore permitted the P.M.O. to engage in general practice and would pay the holder of the post £100 or £200 as opposed to £700 or £800 a year. It was, the



writers said "niggard and parsimonious" (242). In March 1887 it repeated that the combination of insanitary conditions, the plank bed and deficient dietary was contributing to the high death rates of convicted prisoners:

We have had repeatedly to comment on the deaths of prisoners in gaol from pneumonia or suicide or other causes, and we are repeatedly told that these are the exceptions - that no system was ever more perfect. We doubt it ..... (243).

The BMJ again took a more defensive line, commenting in the same month on the low death rate inside, the low level of operative surgery opportunities for the ambitious surgeon and the lack of heavy work for convicts which meant that the prisoner was "not likely to fall a victim to the host of diseases to which a system lowered by improper and insufficient food, hurried meals and overwork is liable" (244).

These issues continued into the 1890s. Once more, The Lancet published a long article from one of its correspondents complaining about "two main subjects of unfavourable criticism .... the prevalence of insanity and the death-rate" (245). The writer maintained that the combination of the very scanty diet and the further reduction in the amount of food as a form of punishment meant that the prisoners "are reduced to such a state of weakness that it often happens they leave prison physically unfit for work" (246). R.F. Quinton, the M.O. at Wandsworth responded by taking issue with the statistics on which the correspondent's arguments were based. Again he raised the question of the general discipline of the prison system:

I yield to none in the desire to shield the prisoner from the consequences of his own misconduct, or it may be, misfortune; but as the Home Secretary pointed out in the circular to which your correspondent alluded, "it must be remembered that prisons are places of penal discipline," not places where prisoners may retire to recruit their health with a view to fitting them for hard work on their discharge (247).

This view was supported by another prison doctor two weeks later.

Writing again in The Lancet Dr Thornton argued that:

It is not always remembered by writers that the inmates of a prison are largely made up of the scum of our population ready for any disturbance if the government is lax, and lax prison management is not a kindness nor is it safe (248).

As ever, the BMJ was more circumspect in its analysis criticising the "chorus of excited voices" which arose amongst some sections of the community when a sudden death occurred in custody. The journal's writers pointed out that:

so difficult and delicate must be the duties of guarding and caring for the weeds of our modern civilization, that trust must play a part in the public mind when that public is in the enjoyment of the comparative safety procured for them by the severely taxed officials whose lives are spent in constant intercourse with this scum of humanity (249).

### The Ideological Context of Prison Medicine.

Such views, and the on-going question of the relationship between discipline and medicine took place in the context of the increasing identification of a separate class of criminals who either by heredity or environment, or a combination of both were propelled

into criminality. From the 1870s Social Darwinist thought dominated the debates about what should be done not only about this class but also about the idle, the feeble-minded and imbeciles whose increase threatened the foundations of order itself. Increasingly, the medical expert became a pivotal figure in these debates. Interventions were based on:

expert decisions (certified by doctors, psychiatrists, social workers etc) regarding the normality or pathology of 'characters', 'mental or moral states' and 'modes of life'. These decisions which need not be publicly explained, are based upon an expertise in the 'human sciences' that is not widely shared nor easily challenged. According to this logic, sentencing becomes less a matter of justice and more a question of proper administration and diagnosis. The norms of the human sciences become a new kind of raison d'etat, whose demands justify serious departures from the usual terms of the law (250).

This process of normalisation saw the extension of the doctor's forensic network into the mind as well as the body. Concern about the increase in insanity (a concern which was often initiated and articulated by the doctors themselves) allowed the profession to claim the insane as their own for medical intervention. In an editorial comment the BMJ maintained:

Our highest privilege is to extend our ministrations to the mind as well as to the body, to offer to erring brothers the hand of help, to bring back to honesty and wisdom those who through misfortune and weakness have fallen far away from both (251).

As David Garland comments, this period, particularly between 1876

and 1900, saw a:

remarkable proliferation of discourses of control which had endeavoured to break the classicist symmetry which held between legal forms and penal control. These knowledges and the techniques they proposed, though highly diverse and contradictory inter se, nonetheless were united by a general programme of intervention based not on a legal philosophy but upon a positive knowledge of (human) objects and the techniques which would transform them. Individually and collectively these discourses provided disciplinary resources as well as 'scientific' legitimation for a transformation and extension of the penal apparatus (252).

Such scientific developments included a discussion of the use of condemned criminals in cholera experiments in India which if they survived their lives would be spared (253). Similarly, The New York Medical Record reported on a condemned prisoner in Hawaii whose sentence was commuted to life imprisonment when he participated in an experiment involving leprosy (254). Closer to home, The Lancet in a leading article headed The Sterilization of the Unfit written in February 1889, argued that the hereditary transmission of disease was now "incontestably established", "like produces like", "the healthy parent is likely to have healthy offspring" and "the unhealthy parent tends to transmit his or her defective type of physique" (255). The journal enjoined its readers to "plead for truth" because it was their duty to:

instruct and forewarn ..... We are responsible for the diffusion of the light that is in us, and for the employment of our peculiar authority in promotion of the purification and well-being of human society (256).

Thirteen years later, R.R. Rentoul, was more explicit as to who should be the focus for sterilization programmes:

those suffering from leprosy, cancer, epilepsy, idiots, imbeciles, cretins, weakminded under restraint, lunatics, persons with advanced organic diseases ... prostitutes ... mental degenerates ... the sexual degenerate ... confirmed tramps and vagrants, characters well known to workhouse officials and to the police ... confirmed criminals (257).

The space within which the doctors worked allowed these views to co-exist with Havelock Ellis' contention that there was a direct connection between the length of the ear, criminality and sexual abnormality. Among criminals it was common to find "projecting or ... long and voluminous ears" (258). It allowed space for Huxley's contentions that there were natural differences between individuals and races and that:

Physiology teaches us not only that the bodies of men differ naturally in size, strength, and capacity for development, but that the natural differences between human brains in size and richness of convolutions are an index to intellectual and moral differences. Any philosophy that ignores such a fundamental fact becomes thereby futile and delusive. A true philosophy must recognise and adjust the relative parts played by natural endowment and educational training, taken in the widest sense (259).

It allowed space for H.P. Hawkins to discuss the question of moral imbecility and crime deriving from the case of a young woman whom he visited in Holloway. Although falling short of the "old-world legal standard of insanity", she was, nonetheless, "suffering from the faults or defective surroundings of her ancestors" (260).

The Lancet continued to argue that it was prison doctors, rather than governors who were ideally suited to discuss the question

of criminality and that the Prison Commissioners should not be content with "vague expressions of opinion by the governors but will obtain definite medical data on the authority of the medical officers of their prisons" (261). The journal spoke confidently about what medical science could offer the authorities. In 1892 it told its readers that:

Criminals, it will be admitted generally come far short of a high or ideal standard of brain, body and mind. That being accepted the next step is to work in the field it prescribes, taking all that enthusiasts like Lombroso, Mantezazza or Benedict can offer of sound or even suggestive material and utilising every opportunity afforded by our more intimate cognisance of the life, normal and abnormal seething around us to accumulate the observations and the facts on which sound induction must be based .... science will work on the more humane view that society is responsible for its degenerative types and that it must leave no effort untried for their rehabilitation till with the establishment of sounder and healthier conditions it creates a social organism in which crime will become as preventable as disease (262).

At a meeting of the Psychology section of the British Medical Association in July 1892, Jules Morel called for the application of what he termed the "medico-psychological service" to all recidivists and all the "great criminals". This in turn would allow doctors and psychologists "to make up very complete reports of the mental state of the convicts" and:

It would allow us to class ... delinquents, and subsequently to begin an individual treatment, so far as their cerebral power allows it ... It would allow us ... to make known the undisciplined and those who would simulate mental disease; it would allow us to take the necessary measures to repress their conduct (263).

Morel criticized Cesare Lombroso and his followers for failing

to understand "the importance of the moralization of the criminals ..... " (264).

From the point of view of the medical profession, Lombroso offered only one of a number of possible explanations for the cause of crime. Many in the profession did not base their theories on the narrow notion of the born criminal. This would have restricted and constrained the influence of the profession and narrowed the scope for medical intervention. The Lancet caught this point well in October 1893:

we must not forget that, whilst we know not of any criminal constitution there is such a thing as a degenerate physical type, capable, indeed, of improvement under wholesome conditions of life, but which without these becomes the fruitful soil of moral weed-growths. It is clear, therefore, that whilst by means of police we must, and fortunately can, control the evil wrought by moral depravity, we must, in order to prevent this, associate with such control other and more purely remedial agencies (265).

This view meant that Lombroso's criminal anthropology could be treated with "respectful hearing" despite its "occasional exaggerations" (266). It allowed the journal to discuss operations such as the craniectomy performed on "an idiot girl of four years of age" at the University of Paris. It had first been performed in Montreal in 1877 when Dr Fuller had made "an incision in the cranium of an idiot child with the avowed aim of giving expansion to the cerebrum" (267). By 1893, the Professor of Surgical Pathology at Paris had performed 25 such operations and claimed that 24 of the individuals involved had been 'cured'. While indicating that there had been criticisms of the method, the journal concluded that:

Such interventions practised in cerebral lesions of apparently an even less hopeful character, has often enough realised expectations to warrant not only its repetition, but its extension to all cases in which osseous obstruction of the cerebrum has been fairly diagnosed. The truth, indeed, seems to lie between the methods of both schools - the surgical and the medico-educational (268).

The combined impact of inheritance and moral development, what Lombroso called "diseased development" (269) allowed The Lancet to conceptualise the prison "as a hospital for the remedial treatment of depraved bodies and diseased minds" (270). This conceptualisation can be seen in how insanity was understood. In his presidential address at the opening of the section on psychology of the BMA in August 1900, Dr Percy Smith told the audience that some of the factors that produced insanity were capable of being dealt with by way of:

restriction or prevention. The ravages of alcoholism, the contagion of tuberculosis .... and the marriage of congenital imbeciles, chronic epileptics and persons who have had one or more attacks of insanity, all these offer themselves for the application of preventive measures. The free and unchecked production and propagation of the lunatic, the idiot, the imbecile, and the neuropath constitute a serious and growing danger to the safety of society, a menace to its public health, and a burden to its resources (271).

At the same conference, the relationship between women and insanity was also discussed. In this case, the doctors viewed the relationship more narrowly, pinpointing the deterministic qualities of the physiology of women in the production of insanity. The discussion centred on the correlation between sexual functions, insanity and crime. In opening the debate Dr MacNaughton-James pointed out that:



various affections of the genitalia, internal and external, might have possible correlative mental disturbances and that malpositions and displacements of the uterus and adnexa, inflammatory and neoplastic lesions and perverted sexual habits eg masturbation might give their characteristic colour to mental troubles ..... Insanity might arise from masturbation as well as from the changes attending the onset of sexual life (puberty and adolescence) or its close (the menopause). Psycho-pathology and gynaecology had a common meeting-ground in the sexual ailments of women, and in this field might be found the causes and conditions which in women gave rise to neurasthenia, hypochondriasis, melancholia, mania, and dementia. Hystero-psychoses had their origin in uterine and ovarian troubles, as was now almost universally recognised. Much depended upon difference of environment and upbringing. The sensitiveness of the cultured, refined, and pretty woman of society might result in mental trouble from causes which did not affect the agricultural labourer's wife, the city seamstress, or the factory hand (272).

While some of the speakers deprecated the routine vaginal examination of female lunatics seeing such procedures as increasing the hypochondria of the women concerned, the biological direction of the discussion was underlined by Dr Wynn Westcott of London who contended that in his experience as a Coroner at inquests on 200 women who had committed suicide he found that "the majority were at the 'change of life' and that the younger of these appeared to be menstruating" (273). The previous January, the British Gynaecological Society held its Annual Meeting. The President was Dr MacNaughton-James, who was to speak at the BMA Conference the following August. Again he raised the question of the relationship between menstruation, crime and insanity:

He said that he wished to inquire how far the process of menstruation affected a woman by originating morbid impulses in the various groups of her pelvic nerves which find their response in reflected neuroses in other organs and thus influence the coherence and stability of her nervous acts. Or, again, in what

directions and to what extent the normal fulfilment of ovulation with menstruation developed for the time being erotic impulses, encouraged the state of neurosis generally, or so lowered the psychical and physical inhibitory control as to lead to a hyper-exaltation of the entire nervous system, with increased susceptibility to slight irritations and a weakened will-control that permitted of distorted mental visions and erratic moral acts, vulgarly called crimes, that the woman was helpless to evade or subdue (274).

These arguments are more fully examined in Chapter 6.

Biological explanations of criminality thus co-existed with more sociological views which emphasised the moral depravity and degeneracy generated by communities and environment. Where the line between the two was drawn in medical debate was often unclear. What is clear, however, is that when the medical profession talked about moral disease and degeneracy, and the interventions that were needed, they saw this deviancy emanating from the working class in general and increasingly, identifiable groups within the class.

In January 1873 The Lancet discussed Galton's theory of evolution and argued for the use of 'material' still available in society to arrange well-assorted marriages, to mate the wise with the wise, the healthy with the healthy in order to "secure and keep up a class capable of government and legislation." The reverse side of the evolutionist coin was the criminal class. Could Galton's ideas on "hereditary improvements," the journal asked, "be effectively applied to the diminution of crime?" (275).

The writer went on:

If among any body of the community hereditary transmission of physical and moral attributes is conspicuous, it is among the population which fills our gaols. Look at its general physique. Imperfect cranial development, with its concomitant of feeble cerebration, amounting almost to a retrogression in the direction of the brutes, is apparent in the mass of its members. Intellectually and morally they are imbeciles, intelligence being replaced by cunning and the will reduced to its elementary form of desire. In the struggle for existence, they herd together, deriving constant accessions from the degenerate of the classes immediately above them, and perpetuating themselves amid conditions most favourable to the reproduction of their like. This is not theory. At a late meeting of the Medico-Psychological Association evidence was adduced to show that the "criminal classes constitute a persistent factor in the community, inheriting and transmitting peculiarities, physical and moral, which induce to crime with the force of gravitation." Forty years' experience of the county prison at Perth enabled Dr. Bruce Thomson to confirm this observation, and to suggest means for removing, or at least modifying, the evil to which it points (276).

The journal argued that the class should be broken up, removing its members to "as great a distance from each other as possible." The "moral disease" of criminality should be treated in an atmosphere which encouraged recovery. This should be supported by education in schools which would instruct the child "in his physical and moral constitution":

A leaf might also be taken from our German kinsmen, and periodical inspection of our schools by medical men come to counteract the forming of pernicious habits or to strengthen weak points among the alumni. In this way education would be at once a physiological and psychological undertaking, fitting the youth for such employment as his powers suggest, and finding for every one his congenial place in society (277).

The journal re-iterated these views in February 1879 when it pointed out that there was no evidence that a distinctly criminal type existed. The writer did, however, cite what was termed

the "general law of development" in which:

those faculties which are most used are best grown, and what is determined in the individual is propagated by heredity in the family. There may be families noted for the production of a large number of criminals, but this circumstance is not either accounted for or to be excused by any physical peculiarity, but is wholly explained by the neglect of education or positively vicious training and influence. The evil can be eradicated, with difficulty perhaps in the individual, but easily in the generation, if only the proper moral discipline is enforced. The mischievous and false philosophy propagated under the garb of popular science teaching, in connexion with much that is called psychological physiology, needs to be exposed (278).

Six months later, it trumpeted loudly:

Let the laws of natural growth be applied to the culture of the mind as they are now applied to that of the body. The mental hygiene of the brain is not less important than the physical hygiene of the organism generally (279).

Arthur Griffiths made a similar point in his autobiography, Fifty Years of Public Service. In the book he discussed how he became governor of Gibraltar prison before returning to England to become Deputy Governor of Chatham prison. This occurred in 1869 at a time when "the ingenious theories of Lombroso and his school of criminologists had not been invented ...." (280). He described the prognathous lower jaws, the handle-shaped ears, the lowering brows and the furtive airs of the criminals in his command:

It would have been impossible for me to say that those before me were all born criminals, a type indeed, the actual existence of which does not seem to me to be fully proved; but at least they exhibited many of the traits described, which,

after long experience, I have found to be largely present in the dangerous classes, and possibly in a large percentage of the general population (281).

The transmission of criminal and deviant tendencies by heredity and environment allowed The Lancet to approvingly cite the work of Dr Harris in New York who traced the ancestry of 900 criminals, paupers, lunatics, imbeciles, drunkards and prostitutes to a woman called Margaret who 70 years previously "became the mother of a long race of criminals and paupers and her progeny has cursed the county ever since" (282). In June 1875, the journal described the ordinary inhabitants of police cells as "the lowest of the low, the filthiest of the scum that society throws up" (283).

Medical opinion also took the view that such "scum" could be reformed, that interventions could be made into the minds of individuals "debauched by criminality." This evil acquired:

a new power of mischief by concentration, just as contagious or infectious diseases gain greater virulence, by the aggregation of cases. The mischievous influences are, so to speak, focussed, and, acting and reacting mutually, they develop with augmented energy, and bear bad fruit multiplied a hundredfold. We entirely agree with the opinion that a wise adoption of the separate system would protect the less criminal, and prove increasingly punitive to the more depraved (284).

Medical officers in prisons and workhouses were seen as pivotal in this process of intervention and were better qualified to "bear testimony on these points than governors, who for the most part, know little or nothing of the inner life of the establishments under their nominal control ...." (285). It

was the prison doctors who were seen to be in the front-line when it came to establishing not only the general health of the prisons but also in detecting malingering. The Lancet outlined the ideological context of the M.O.'s work:

The medical officers of these prisons have to deal with malingering of every shape and form. The art, in fact, is practiced amongst convicts with a refinement that baffles description, and seems attainable only by cunning thieves and lazy wretches, who prefer preying on society to earning an honest livelihood, and who for the most part occupy our prisons. All this adds considerably to the difficulties of their work, and if errors of diagnosis are made occasionally, they are generally in the prisoners' favour (286).

This praise was part of a more general claim for the profession to be taken seriously by the state and "to accord to medicine the status and scope of skilled service." In that sense it was necessary for the state to see:

the science of life is an integral part of political economy, and the development of physical and moral health - by sanitary conditions affecting the whole population - should be the primary aim of government. The intimate relation of bodily weakness, infirmity, and decrepitude with poverty and crime, is beginning to be perceived. When may we hope to see the logic of facts working out practical conclusions? (287).

In November 1888 The Lancet argued that one method for dealing with society's outcasts was to increase the period prisoners spent in separate confinement. The journal had been led to this conclusion by a paper from Dr Gover, the medical superintendent of Millbank. It felt that such confinement and the treatment within the regime should be directed "not less to the formation of criminals than to the repression of crime." It concluded that

since the infliction of all punishment was:

now placed under efficient medical vigilance and control, we shall be prepared to welcome a reformation of prison rules which will enable the system of separation to be carried out for longer periods than at present, and its effects to be more fully developed in that very numerous class of criminals to whom it may with great moral advantage be applied (288).

Gover demanded a three year period of separate confinement which would allow the prisoner to have some industrial, occupational training "without interference with the discipline of the prison" (289).

Gover was one of a number of P.M.O.s who worked around this time and whose views outlined in their autobiographies indicated the clear connection between discipline, morality and control. R.F. Quinton's Crime and Criminals described his life as a P.M.O. in the late nineteenth and early twentieth century. Quinton was quite clear about the cause of crime, and how it lay within the individual:

The habits and ways of the criminal class are frequently inscrutable, and invariably unlike those of normally constituted people. Some defect or weak spot in character is constantly found to accompany criminality. Want of self-restraint, lack of moral principle, callousness of temperament, selfishness, idle habits - these are formidable obstacles to reformatory effort which too often prove insurmountable (290).

From this starting point he argued that any misery or suffering that prisoners experienced depended "much more on the temperament and antecedents of the offenders than on any cruelty inherent

in the system" (291). He contended that the relative luxury of prison food and treatment had considerable attraction for large numbers of people whose living was precarious. In that sense, "the restfulness of it, and the monotony of the dinner bell appeal strongly to thousands of the vagrant class" (292). As with many social commentators of the time he was concerned with demoralisation and the emergence of a criminal population whose roots lay within the organization of the society itself (293). This, however, was no radical attack on social structure. Rather Quinton was eager to emphasise how society was:

largely responsible for the manufacture of the vagrant class. Our methods of dealing with them hitherto have been inept and futile, and the encouragement which has lately been given, in the form of eleemosynary doles, to unemployed and unemployable indiscriminately, has tended to the demoralisation of thousands, and converted them into hopeless vagrants (294).

Quinton carried these views into the prison, particularly in his search for malingerers. Rule 42 of the 1865 Prisons Act allowed the P.M.O. to utilise a test of malingering whereby "any painful test" could be administered to detect it (295). He thought that shamming was "constantly in evidence and refusals to work were a daily occurrence" (296). The daily sick list amounted to 10 per cent of the population. There were usually 100 applicants who were seen in 45 minutes of whom "not more than a dozen needed medical treatment of any kind" (297). He described one whose:

main object in life had been to avoid work in any shape or form. He was ignorant with the ignorance of the savage and so devoid was he of anything resembling moral sense, that the rights of property and the *raison d'etre* of the penal laws were to him



dark mysteries and they remained so to the end (298).

Quinton supported this view with a more general description of his first days as an Assistant Surgeon at Portsmouth Convict Prison in 1876. The prison contained 1200 prisoners:

The armed sentries, gates and bars, fetters and triangles, with other paraphernalia of the establishment, were sufficiently stern and gruesome features to me as a novice entering the service to relieve suffering, but they counted as nothing when compared with an actual acquaintance with the human beings for whose control and safe-keeping they were required. I felt that I had been suddenly transplanted into a veritable community of pirates capable of any, and every crime under the sun. Although penalties for misconduct were very severe at the time, they had apparently but little deterrent effect (299).

He was also quite clear where he stood on the question of prison diet and the relationship of the diet to punishment. He described how requests for a change of diet "came in shoals." He started from the position that it was "fairly liberal in quantity, and in a physiological sense should have sufficed for all but a small percentage of exceptional cases." He supported the use of dietary punishment:

..... it is often found to be the only way of appealing to the feelings of an idle or in-subordinate person, short of the infliction of corporal punishment. Prisoners will light-heartedly submit to loss of remission marks, loss of stage privileges, loss of gratuity, or even to cellular confinement, if their diet is not reduced (300).

He concluded his book by reinforcing Darwinian imagery and explanations, tied once more to strong notions of less-eligibility:

The free and bracing air of America may perhaps produce a type of criminal to which we are unaccustomed - one who is capable of being turned into a useful citizen by a pampering system - but it is as certain as anything predictable can be that such a system would demoralise criminals as we know them. it is not unlikely that I may be called a stony-hearted official for taking a cold common-place view of the treatment that is most calculated both to reclaim prisoners, and to reduce crime, but I have at all events more than an arm-chair knowledge of the subject, and more than a nodding acquaintance with the material to be experimented on. These credentials must be my excuse for denouncing a pampering system as one that is likely to cause much more harm than good. Pampering, in fact, is just as unsound in principle, and just as futile in practice, with a naughty man as it is with a naughty child. No responsible person who has had to deal with criminals in this country would contemplate offering the profuse hospitalities of an American prison to the 25,000 vagrants who entered English prisons last year, without entertaining very grave misgivings that he would be encouraging, instead of checking crime. The conditions of life in America are of course quite different to what we see in England. The struggle for existence is much keener here, more especially for the class who mainly supply the prison population. If, then, our prisons offered such attractions as are here described, thousands would avail themselves forthwith of a rest-cure under conditions that would really mean to them Oriental splendour and luxury (301).

John Campbell's account of his experience as a Medical Officer expressed similar views. Campbell was a M.O. for 30 years and published his autobiography in 1884. The book covered a range of areas that he had come across during his service. Again there was an important overlap between moral degeneration and criminality. He expressed this connection in forceful terms describing permanent criminals as those men who were "so thoroughly debased and hardened as to resist any system of treatment." Habitual criminals he concluded:

when not undergoing sentence in prison, depend on doles, or indulge their criminal propensities by acts of theft, mischief and outrage having an inordinate dislike to earning a livelihood by honest industry (302).

Campbell linked this predisposition to crime, to degeneracy and heredity. Lombrosian language and imagery pervaded his views of criminal behaviour:

The foregoing remarks on some of the bodily ailments to which the criminal classes are more peculiarly liable, are sufficient to show that the medical officers of prisons who discharge their duties faithfully have no sinecure. This is more especially the case in an invalid prison, where they have to contend with aggravated, chronic, and intractable diseases from hereditary predisposition, or from constitutional degeneracy, the result of intemperate and vicious habits. These remarks apply with even more force to mental affections, which occur among invalid prisoners in every form and degree, from simple weakness of intellect to well-marked lunacy. Mental deficiency is by no means uncommon among habitual criminals, and prevails in many different forms. Some display a marked degree of dulness or stupor; others sharpness and cunning more allied to the tricks of monkeys than the acts of reasonable men.

The physiognomy, as well as the conformation of the skull, is often remarkable; and the result of many post-mortem examinations has proved that the brains of prisoners weigh less than the average, and that a large brain is an exception. These cases of mental deficiency or disorder are at times a source of great anxiety to the medical authorities, and this is increased by the inadequate means provided in the prison for the management of such cases (303).

Like Quinton, he supported order, regularity and discipline in the prisons as the fundamental mechanisms for dealing with criminals and, in particular, for reclaiming them from the vice and debauchery of criminal association:

Although I am in favour of a mild and encouraging

system, with a view to the improvement of the moral and physical condition of convicts, I also desire to see the strictest discipline carried out, so as to suppress any tendency to insubordination or disobedience to prison rules.

The system of a preparatory prison, so much advocated some years ago, with a view of allowing convicts, on the eve of their discharge many indulgences in the shape of improved dietary, greater liberty, and increased remuneration for work, might be carried too far; for prisoners undergoing sentences for crimes more or less heinous have no right to expect luxuries, or anything more than kind and generous treatment, as long as they are industrious and amenable to other rules of the prison. By making the closing period of imprisonment agreeable, the deterrent effect must be greatly impaired (304).

In a paper in The Lancet in October 1895, Dr Gover who was now the Medical Inspector of Prisons, again brought out the two distinct strands in the thinking of the doctors and illustrated the room for intervention that flowed from them. At the heart of this intervention lay discipline:

Whether the somewhat pessimistic doctrines of the criminal anthropologist be accepted as the basis of action, or the more hopeful view of those who regard a proclivity to the commission of crime as the natural outcome, in the majority of cases, of unfavourable surroundings from infancy upwards, there can be no doubt that the criminal elements in society may be largely reduced by such social reforms as the prevention of overcrowding, by attention to the details of sanitation, by judicious education and by such training as will tend to eradicate habits of idleness. A distinctive feature in the character of the habitual criminal is a distaste for regular labour. The changes that are destined to take place in prison administration and the measure in which society will interfere to prevent the genesis of the criminal during the next century, cannot, perhaps, be even roughly indicated, but it cannot be doubted that the good work initiated by John Howard will be continued in such manner and with such effect that some, at least of the criminal classes will lose their characteristics as criminals, and will be finally absorbed into other classes of the social organisation (305).

Gover's paper appeared in the year that the report by the Gladstone Committee was published. Liberal analyses of this report have consistently articulated the view that the Committee's recommendations on treatment and training mark the beginning of the modern prison system's desire to reform the criminal (306). A critical reading of the report, and its ideological context, however, reveals a more complex picture. As Vic Gatrell points out, evidence to the Committee from the Commissioner of Prisons and "a plethora of prison doctors" dismissed all criminals "as 'morally insane' or as coming of 'degenerate stock' ....." (307). For one prison doctor there was significance in the "'furtive eyes' which he deemed typical of the criminal physiognomy" (308). For Peter Young the classification that the Gladstone Report introduced around reform was compromised "by its being yoked to the more mundane demands of prison discipline .... reform and discipline were collapsed to mean the same thing" (309). The Committee's report extended the power of medical personnel in the prisons. Their work was part of the "scientific and progressive spirit" which The Lancet identified in the Prison Commissioners' report for 1897 (310). The following year, the Prison Act was passed. It enacted in legislation the proposed Gladstone reforms. In a statement in January 1898, the Commissioners discussed the developments that had taken place with regard to P.M.O.s. In 18 paragraphs they provided an outline of the duties of the P.M.O. It covered all aspects of prison life and allowed the M.O. to keep detailed records of his/her everyday dealings with the prisoners. It also enjoined that:

the medical officer shall himself conform to the rules and regulations of the prison and shall support the governor in the maintenance of discipline and order and the safe custody of the prisoners (311).

The Lancet argued that these changes were designed to make the prison system "more elastic and to bring the treatment of the criminal more in accordance with modern ideas" (312). The 1898 Act, in the journal's view, allowed juveniles to be "rescued" through "moral education and industrial occupation ....." (313). For prisoners, in general, it allowed for classification, differential treatment and regulation of the prison diet. Additionally, it symbolised a new regime in which the old idea of deterrence:

gives place to the new principle of reformation; encouragement is held out to those who have casually strayed from the path of rectitude, and the better instincts of the wrongdoer are appealed to in the hope of speedy amendment (314).

These changes increased the influence of the doctors still further particularly in the areas of psychiatric examination, classification and disposal. At the same time, the pay which they received and the status which they were accorded remained low and was the subject for debate in the medical press which the doctors used as a platform to discuss their grievances. This debate, as I shall show, was to continue into the twentieth century. The controversy around management, control and medicine was also to continue into the next century. The BMJ captured both points well when its writers pointed out that not only was an assistant doctor paid less than the Chief Warder and the Clerk of Works but also:

Young men recently appointed will frequently find a sort of moral pressure put on them to back the executive; let them, however, bear in mind that they must be held responsible for any results (315).

As the next chapter indicates this was to remain an ongoing and deeply contentious issue from the turn of the century to the present.

Chapter 5

Medicine, Regulation and Control in the Twentieth Century:

The Continuing Controversy.



As professions, behavioral science, medicine and psychology derive so much of their authority from the service of corporations and the state that it is difficult to see how they can visualise a person scientifically except as an object to be predicted, controlled and improved .... The taste for therapy of verbal or chemical varieties is more than a fad. It has two hundred years of tradition behind it. The abuses of behavior modification and token economy schemes in prison are the fruits, not simply of the behaviorist zealotry of individuals, but of a tradition of psychological thinking that dates back to the blithely reductive assertions of Cabanis and Offray de la Mettrie that men were malleable things (1).

The debates around, and controversy over, the relationship between prison medicine and regulation, which I analysed in the previous chapter, continued into the twentieth century. The first half of the century was to bring a number of significant developments for medical workers within the prison. In Chapter 3 I discussed these developments in the crucial years between 1945 and 1964. In this chapter I wish to pick up the themes of discipline and regulation and to illustrate the continuing influence that they have had on prison medicine from the turn of the century to the present. Once more, I shall be emphasising the dialectical nature of these processes, not only linking medical and psychiatric discourses to wider state concerns around order, control and regulation but also emphasising the limitations placed on these discourses by the questioning actions of prisoners and their supporters.

#### Consolidating Medical Power.

The development of prison medicine in the early years of the

century took place against the background of the consolidation of the medical profession's view of criminality. It was a view which as David Garland points out continued to refute the criminological theories of Lombroso and Ferrero. From the 1870s "prison doctors such as David Nicolson and later John Baker set about redefining 'the morbid psychology of criminals', so as to differentiate a range of conditions rather than a single type" (2). This continued into the early twentieth century when a number of prison doctors including Sutherland, Quinton and Devon not only had psychiatric training and occupied positions within the prison service but also published "most of the major scientific works on crime, written in Britain before 1935" (3). The doctors also began to expand their influence into the academic arena. Maurice Hamblin-Smith delivered the first university lectures in 1921/2 in Birmingham. They were given to post-graduate medical students. Furthermore, "long before Mannheim began teaching at the London School of Economics in 1935 there were courses on 'Crime and Insanity' offered at London University by senior prison medical officers such as Sullivan and East" (4).

This consolidation structured around an "institutionally-based, administratively-oriented criminology" was paralleled by other developments in the space occupied by prison doctors.

First there was the consolidation of their observational role with regard to prisoners on remand. Their gaze was turned to probing, testing, deciding and reporting on those whose mental state gave local magistrates cause for concern. Stephen Watson

argues that this process began in the 1880s when magistrates increasingly used the remand process for those prisoners "whose mental state was suspect" (5). This was enhanced by the Prison Commissioners who in their reports from the mid 1890s noted an increase in prisoners who were ultimately found insane. This was attributed to the "growing practice of remanding to prison for a period of medical observation, persons who have committed some offence while in an apparently unsound state of mind" (6).

In 1907 The Home Secretary indicated that the policy of the Prison Commissioners was to place "mentally deficient prisoners ..... under the special charge of the medical officers of the prisons." In addition, they were to be continuously in the personal care of "selected warders" (7). Finally:

The medical officers regulate their discipline and diet and allow them such employment as is suited to the condition of each individual. In addition to those so classified there are other prisoners temporarily under observation to ascertain their mental state (8).

The doctors were to consolidate and increase their influence with these prisoners in the coming years. By 1920 they were attending conferences and publishing widely in the area of criminality and mental illness. In that year, a number of them attended a conference at Rampton hospital. They included Dr Norwood East then the P.M.O. at Brixton, Dr Ahern the M.O. at Liverpool and Dr Murray who was M.O. at Parkhurst. Apart from Murray "everyone at the conference eventually published on moral imbecility" (9). Observation and surveillance were

key techniques in the doctors' repertoire. For Watson the observation techniques and mental testing of the 1920s were direct heirs to the strategies of isolation developed in the early nineteenth century:

That the prison medical officer should appear to be encroaching on the authority of the judiciary with the latter's ready connivance appears less surprising if we situate the prison within the wider context of what Foucault calls 'the Declaration of Carceral Independence' that he claims marked the birth of the penitentiary. Isolation, which Foucault identifies as one of the key principles of the early penitentiary eventually became a technique that marked the frontiers between the judicial and penal systems. The acquisition of the prison M.O.'s expertise in mental disease was directly related to an increase in the practice of remanding for observation those criminals who magistrates considered to be of doubtful mental health. Observation thus established the prison M.O. in a new independent role as an arbiter of mental health, and especially of those problematic cases on the borderline of criminal responsibility, the mentally deficient. Although the ability of the prison to 'rectify the penalty as it proceeds' may have had less impact on the English penal system than a reading of Foucault might suggest, developments in the early twentieth century were continuous with the techniques of observation and control that were part of the prison from the early nineteenth century (10).

In 1922 Sir Evelyn Ruggles-Brise, the Chair of the Prison Commissioners recognized the P.M.O.s as experts in mental disease as did the Prison Commissioners themselves and organizations such as the BMA's Parliamentary Bills Committee (15). When the Report of the Committee Appointed to Inquire into the Pay and Conditions of Service in the Prison System was published in the same year the authors found the M.O.s at Brixton, Liverpool, Manchester, Birmingham and Leeds were being remunerated with "considerable fees for giving evidence in court on the mental condition of

prisoners" (12). Norwood East, the M.O. at Brixton, later to become Medical Inspector of Prisons, was producing 700 to 800 reports a year on the mental condition of prisoners. At Liverpool, Maurice Ahern was producing 300 reports annually (13). Some doctors were contending that their position "meant ..... the courts should always consult them before sentencing offenders" (14):

The whole question of the correct treatment of offenders is a purely psychological matter. No prison punishment (corporal, dietary, or confinement to cell) can be inflicted without the concurrence of the medical officer. It is but a short and logical step to the position that no sentence of imprisonment should be awarded, or any order of court made, without the due attention being paid to the findings of an adequate medical examination (15).

The Home Secretary himself, gave added legitimacy to this development when, in February 1922, he opened a series of lectures on the subject of "The Mind and What We Ought to Know About It". He pointed out that "more and more" scientific knowledge was being generated "every day" in relation to "temperamental cases." Additionally, "great scientific men" were devoting their lives to the subject. For Borstals:

We want to have not men trained in the Army - soldiers - we want schoolmasters and doctors combined; we want men who can study each individual case ..... (16).

The acquiring of a reputation as medical experts thus arose from the doctors' own investigations into weak-mindedness and insanity. According to Watson, this reputation developed from the occupational setting in which they worked and "especially from the

opportunity this provided to observe different types of mental disease" (17). It was this factor, rather than any obvious attempt to assert 'professional dominance' that helped to extend the influence of the doctors' power. While Watson is correct to pinpoint the increase in this power, he does not fully recognize that the doctors increasingly did see themselves as a body of men best equipped not only to analyse social problems but, importantly, to provide solutions to these problems within and without the walls of the penitentiary. At the same time, the state via the Prison Commissioners and the Home Secretary sanctioned and supported the claim to expertise which the doctors articulated.

Despite this increase in the power to name, the position of the doctors was not without its own contradictions and imposed limitations and challenges. As a professional group they were not totally united on the terrain of a clear-cut, strategic psychiatric programme. There were divisions between them as to the interpretation of the precise relationship between psychological processes and social action. There was even a residue of nineteenth century Lombrosian theorising in some of their pronouncements. As late as 1927, Norwood East wrote in his Introduction to Forensic Psychiatry that "the measurement of the head circumference may be of value" (18). Twenty years previously, J.F. Sutherland had written that "the existence of a criminal physiognomy cannot be gainsaid .... coarseness, scars, expression and look tell their own fate. They are the hallmarks of alcoholism, debauchery, ruffianism, dishonesty, lying and unchastity" (19). Maurice Hamblin-Smith on the other

hand, described how he was a "convinced and quite unrepentant Freudian" (20) and that "imprisonment must be regarded as a mode of treatment rather than one of punishment" (21). He had a number of suggestions as to how such treatment could be instigated including better pay and conditions for prison officers, the establishment of different kinds of prisons and the "indefinite detention" of recidivist offenders in colonies where "they might be accompanied by their wives and children" (22). He concluded:

Let us regard a prison as a place of moral regeneration, and as on the same plane as any other hospital (mental or general). Both hospitals and prisons are, at present, unfortunate necessities. But we could be as proud of a well-ordered prison as we are of a modern hospital. When we adopt this altered attitude, and only then, shall we make the progress towards the cure of that social disease known as crime which we have made in the case of other mental and physical diseases. That progress has been made by the study of the causative factors of disease, and we now aim at prevention rather than at cure. So will it be with crime, when instead of blaming and blindly punishing the offender we endeavour to understand him (23).

While state servants such as the Prison Commissioners and politicians like the Home Secretary welcomed the doctors' expert interventions, this was not reflected in an increase in either financial rewards or status. From the turn of the century they were locked into an on-going debate with the Treasury about the legitimate financial rewards for their work. It was a debate which was to continue until the present (24).

In a letter to the Home Secretary, written in January 1905, Ruggles-Brise commented it was "to be regretted that this

important body of officers should be in a state of chronic dissatisfaction with their conditions ..." (25). The following November, the Home Secretary wrote to the Treasury pointing out that changes in dietary, labour, punishment, mental and physical conditions, sanitation and ventilation had been to render the duties of P.M.O.s:

more onerous than they were even ten years ago. Further, there is at present on the part of Judges and magistrates a growing tendency to regard crime from a medical standpoint. Hence the opinion of the p.m.o. comes with increasing frequency to have weight in the question of the course to be followed in the treatment of a criminal by the court in sentencing him or by this Department subsequently (26).

The letter also pointed out that judges and magistrates were increasingly recommending that a prisoner's mental or physical condition be "specially observed and that his release or continued detention for the full term of the sentence passed on him be made conditional on the view taken by the medical authorities" (27). Indeed, the Home Office had issued a special order to Medical Officers in April 1902 urging them to attend courts to give evidence if required "in any case where a question is likely to arise with regard to a prisoner's mental condition" (28). The doctors continued to forcefully argue their case. Their views showed a new-found confidence in their role as experts especially in observing the mental condition of prisoners on remand. The deputy P.M.O. at Pentonville expressed these views clearly in January 1919:

.... the work of prison m.o.s has in recent years become far more complicated and important. We may



indeed claim to be the only body of men in the country whom training and experience have fitted to acquire a competent knowledge of scientific criminology. Moreover in our ordinary duties we have to be familiar with other branches of medicine, in respect to which the general practitioner is accustomed to rely on specialists. An efficient prison m.o. must, for example, be somewhat of an expert in such widely different diseases as insanity and venereal diseases (29).

Ruggles-Brise followed this up in March in a letter to the Under-Secretary of State at the Home Office calling for "the very urgent need for the re-organization of the medical service of prisons"(30). By February 1920, the M.O.s had rejected the Treasury's suggestion for reform which meant that "a grave crisis is anticipated" (31). These words, as I shall indicate, were to prove prophetic.

It was not only pay and conditions which were contentious issues. The role that the doctors played in the disciplinary regulation of prisoners continued to be discussed. Their concern about malingering remained an ongoing one. In 1892 it had become such an important element in their work that it had been cited as part of the demand for better pay and conditions (32). When malingering was suspected the prisoner was placed in the observation cell where surveillance was intensified. This concern took place in the wider context of the problem of discipline and the maintenance of order. In December 1904, Dr Smalley, the Medical Inspector of prisons, advocated the retention of the loose canvas jacket in prisons to cope with disturbances. He supported this by outlining the different restraints that could be used which were broken down into three categories. These he termed: "plenty of attendants", "chemical" and "mechanical" (33). Smalley outlined the problems with each. Attendants could lead to deep "desperate resistance"

and to charges "in the case of prisoners of unnecessary violence having been used." He went on to describe chemical or medicinal restraints, which were used to:

signify the administration of narcotic drugs in order to control noisy and violent patients. This form of restraint has the disadvantage that it often depresses the vital powers, deranges digestion and is of doubtful benefit in some cases of delirium (34).

He concluded mechanical restraint was the:

best form to use with certain prisoners e.g. when the violence arises, as it sometimes does, from a mixture of mental excitement and temper or when restraint is necessary in order to retain surgical dressings on a wound or ulcer ... said mechanical [restraint] is preferable to restraint by personal attendants owing to the possibility of bruising etc. and of after charges of personal assault and injury, when it may be very difficult to elucidate if unnecessary violence has been used (35).

Smalley's annual reports were also concerned with highlighting the problems feeble-minded prisoners posed for prison discipline. This group "who by reason of their mental defect are incapable of conforming to ordinary prison discipline" (36) were regarded as an identifiable mass within the population at large. Many of the debates around social policy and criminality in the first two decades of the century were taken up with what should be done with them. The term had first been used by Sir Charles Trevelyan, who was a member of the Council of the Charity Organization Society. He had used it in 1876 and it became institutionalized in 1904 with the appointment of The Royal Commission on the Care and Control of the Feeble-Minded. It reported in 1908 and included amongst its members Doctor Horatio Donkin who

was the Medical Commissioner of Prisons (37). The Mental Defficiency Act which followed in 1913 was couched in terms which indicated the threat that the increase in the feeble-minded posed to the society. As David Garland points out "from being a local difficulty faced by the managers of casual wards and prisons, the question of 'the feeble-minded' had become a degenerative threat to the race and to national efficiency" (38). The Act extended state control over a range of groups while simultaneously establishing "yet more specialist enclosures where such defectives will be detained and treated" (39). In that sense, this Act and the five statutes that immediately preceded it saw:

the extension of the role of state, which becomes the subject of wider and more penetrating forms of social regulation; promoting expertise and the accumulation of disciplinary knowledges; and the establishment of practices of individualisation, accompanied by rhetorics of reform (40).

Smalley himself had pursued a similar line arguing for the permanent detention of this group in a "suitable institution" (41).

As The Lancet commented in October 1908:

the characteristics of the individuals who come into this category and the difficulties which beset their treatment in prison have been pointed out again and again by Dr Smalley in his annual reports for several years past; and it is satisfactory to note that the views on this matter which he has so insistently urged have been fully confirmed by the report of the Royal Commission on the Care and Control of the Feeble-Minded (42).

Smalley's identification of this group as problematic was an integral part of the on-going discussion around eugenics which

itself was a central part of medical debate. While the well-organised eugenics lobby forcefully put the case for sterilization it did not achieve hegemony. There were deep divisions within the medical profession over the scientific status of the lobby's theory and methodology (43). What is important is that their argument was part of a "social programme" in which social questions were "fundamentally depoliticised" and questions of power and its distribution were replaced by "questions of individuals and their improvement" (44). Medicine was increasingly at the centre of this displacement process both in the society at large and within the prisons.

The increase in the power of the doctors was also challenged by prisoners themselves. The move towards greater medical intervention into their lives did not lessen the disciplinary thrust of penal regimes. Indeed their accounts often highlight the role that medicine played not only in procedures of punishment but in contributing to the overall disciplinary atmosphere of confinement. As I indicated in Chapter 3, the Prison System Enquiry Committee established in January 1919 by the executive of the Labour Research Department was an important vehicle for allowing prisoners to speak about life inside. It was particularly important in the context of the centralisation of the prisons in 1877 and the subsequent denial of information to the outside world. The Enquiry's report published in 1922, provided a range of material on the P.M.S. and its relationship to prison management. The Enquiry found that medical care for the confined and the treatment of the sick was inadequate; prison hospitals were being used for the purposes of solitary confine-

ment; there was an absence of hospital treatment in small prisons; and that there were questions to be asked about deaths in custody. Finally, the increasing role the doctors were playing in classifying mental illness and lunacy was based on little training or qualifications. As the Report pointed out:

We believe we are correct in stating that none of the medical officers even at Brixton or Holloway prison, to which hundreds of cases are sent for mental observation or at Parkhurst prison, the prison to which physically and mentally weak convicts are sent have any special qualifications for the diagnosis and treatment of mental cases. Sir E. Ruggles-Brise states that all medical officers are required to have "a practical knowledge of insanity"; but the phrase appears to signify little (45).

This lack of knowledge was compounded by the involvement of the medical staff in investigating "shamming". The M.O. on the authority of the Visiting Committee or a Commissioner could apply a "painful test" to the prisoner. At Dartmoor the prisoner could be placed in a shower bath:

Suppose a telephone box constructed of iron bars, and enclosed in a huge glass coffin. Within the bars is just room for a man standing upright, who can be easily viewed from all directions through the bars and glass. A warder's explanation of this apparatus is as follows: A convict apparently becomes insane and is suspected of shamming. He is removed to hospital, stripped and placed in the cage which is guarded by a warder and inspected by the doctor. Above the convict's (supposed lunatic's) head is an ordinary shower bath apparatus which is turned on and left on if need be for 15 minutes (but not for more) (46).

If the convict was shamming then the temperature of the water, plus the iron bars would make him "confess to the doctor that

he is shamming and so escape further treatment" (47). On the other hand, it was felt that the genuinely mad prisoner would suppose this was treatment for his condition and there would therefore be no need for any confession.

The report raised further questions about insanity in prisons, particularly with respect to how the structure of the prison regime itself contributed to the prisoner's mental demise. The authors described the effect of the regime on a black prisoner:

From the moment of his entry he seemed dazed and crushed; the cold cells and wintry weather combined with the solitary confinement, completed his undoing, for he rapidly developed symptoms which caused the doctor to place him in a gated cell for "observation." At first he was allowed cell furniture; utensils, bedding, slate, picture book (for he could not read), but he was deprived of these some days later, either because of a "crime" or the development of dangerous symptoms, and was also "taken off work." Having nothing to do, he sat hour after hour dazed, shivering and gibbering, nought to take his thoughts away from himself or interest him in the slightest degree. He became worse, was removed to a mat cell, and given a blanket for additional warmth. He was not allowed to leave his cell, to which he took a deep dislike, for several officers had to force him back the first time he went out. All his slops were carried away by another prisoner escorted by a warder.

I was taskmaster's assistant and had ample opportunity for going about the prison unescorted and was thus able to observe the unfortunate men under observation as I passed their cells. The negro especially attracted my attention; huddled in a corner of his cell, silent, crushed and with a vacant gaze. Shut up, like an animal in a box fed at fixed intervals, peered at every half-hour; thus he was whilst his sanity rotted.

Several times I saw him standing in the centre of his cell gazing vacantly at a divested garment or part of his naked body. I tapped at his door to attract his attention, but he was too obsessed to notice me. Then he would look around with vacant, staring eyes, which had an expression of unutterable defeat (48).

They concluded that the "prison discipline generally, and the

'observation cell' arrangements in particular, are calculated to drive some persons to insanity" (49).

These conclusions were reflected in the accounts by other prisoners about life inside at this time. The regime behind the prison walls in the 1920s and 1930s was still hard, uncompromising and underpinned by violence when order was threatened. Wilfred MacCartney's account of his experience in Parkhurst described in grim detail the standard of medical care, the superficial nature of the medical examination and the involvement of the doctors in a number of disciplinary duties. For MacCartney "the medical officer is the most important, powerful and the best-paid official in the gaol. His word overrules everybody. What he says goes, and he has a large staff" (50). The M.O.'s duties involved being present at floggings. Furthermore, if a prisoner continually rebelled against the regime he was put on the observation landing in the infirmary "so that the doctors can keep him under observation" (51). This observation for MacCartney was used to control the prisoners:

In many cases men were kept upon the "barmy" landing, punished frequently, lost remission, and then a few weeks before their sentence expired were certified and whisked off to Broadmoor or some institution for the weak-minded ..... Men are for years treated as normal for the purpose of punishment, and then deemed insane or weak-minded as their day of freedom approaches. Once an accident, twice a coincidence but three times a certainty (52).

He maintained that during his eight years in Parkhurst he came into contact with approximately nine doctors and "with one or two exceptions they impressed the prisoner as a heartless

and indolent and incompetent crew" (53). He described their involvement in the rationing of food:

This starving and feeding-down of the convict are done to render him more amenable to the brutal discipline. I once heard a medical officer say, "Well, a little starvation makes 'em wonderfully reasonable." I remember asking Dr. Norwood-East the Prison Commissioner, if it were a scientific fact that a monotonous diet was injurious to the metabolism. He said, "Yes." Then I asked if 2,550 consecutive meals of margarine, cocoa, and cheese constituted monotony. He said, "Get out before I put you on report for insolence" (54).

For some prisoners, this combination could have disastrous consequences:

In many cases, prison doctors are wretchedly incompetent. The treatment of a man called Jones who was doing three years for false pretences is evidence of this incompetency. After sentence he was examined and reported fit at two prisons. Two days after the second of these examinations he arrived at Dartmoor, and was there examined by Dr. Battiscombe.

Battiscombe has the name among the convicts of being the most careful doctor in the service. He put all convicts sent to Dartmoor through a very thorough examination.

Phelan, a convict of great intelligence and wide experience, told me that Battiscombe was the best doctor in the west of England. This sounds exaggerated, but Battiscombe must be pretty good.

Anyway, on examining Jones, who had been passed by gaol-doctors as fit to work in the hardest prison in England, Battiscombe found that the poor fellow was in an advanced stage of T.B., with one lung completely gone. Jones was put to bed immediately, and never left it again except to come to Parkhurst. He died almost in my arms a few days after Christmas 1933 (55).

Red Collar Man's autobiography published in 1937 told a similar story. For him, the doctors "with few exceptions are very callous



in jail" (56). He identified their involvement with disciplinary activities including flogging where the man's back would be "covered with long red weals and the skin is broken and bloody. These marks never fade right out, but remain for life" (57). Like MacCartney, he saw the insane label being used against troublesome prisoners. As he pointed out, "sane in jail and take your punishment come what may, but insane when freedom beckons and so be locked up again" (58). Order and security were maintained through the use of escape lists, locating potential escapees in particular cells and keeping a dim light burning in the cell throughout the night. Clothes were left outside of the cell door in the evening. Strip searches and cell turnovers were carried out at least once a month. Recalcitrants were placed in one of the seven silent cells which were like a "ghastly Chinese puzzle box" (59). The cells were made of concrete and heavily fortified, there was no heating in the winter:

These black holes were completely devoid of any furniture whatever. For a bed there were three boards set in a concrete border about 4 inches off the floor. At one side of the cell there was a sawn off trunk of a tree clamped to the wall and embedded in the concrete floor. The only ventilation was a small iron grill about eight inches by four, high up in the wall.

In the ceiling was a window of frosted glass, inches thick. Outside each cell door, to the left, was a ladder let into the wall, leading to the roof of the cell. This was used by the warders to climb to the roof to spy on the lag confined inside by means of a small spy hole which gave a complete view of the interior of the cell.

A lag confined in these cells on punishment was only allowed out for one hour in the twenty-four for exercise. From 7.30 a.m. his bedding and mattress were removed from the cell and not returned until 7 p.m. each evening (60).

Body-belts, steel bracelets and strait-jackets were also used. If these techniques failed then violence was a possibility. Such beatings were not only described by prisoners at this time. In his autobiography, The Wall is Strong, Gerald Fancourt Clayton, the ex-governor of Wandsworth, described in frank detail an incident at the prison in the late 1930s. Two prisoners who escaped, were recaptured, taken to the punishment cells and in his words given "a good hiding" (61). Clayton described what happened next. His attitude to both the prisoners and to those who carried out the assaults provides an interesting and still rare insight into the mind of a highly-placed state servant:

When I went to see the men in the punishment cells I noticed that the first man had bruises on his face, and I asked him how he got them. He replied that he had fallen from the boundary wall on his face on to a heap of stones. I then passed on to the other, the nastiest type of Jew and a well-known mischief-maker. However, at that time he made no reference to what had happened although he was marked.

In reporting the escapes to the Prison Commissioners I did not mention the fact that the men's faces were marked. The next day, however, the mischief-maker complained that he had been assaulted, and I reported the whole circumstances to the Prison Commissioners. Later I learned that he had managed to arrange with a pal who was going out the following day to tell his wife what had happened. She was to go to her M.P. and get him to ask if it were true that the two men had been assaulted by prison officers after attempting to escape. I reported this also to the Prison Commissioners. The fat was now properly in the fire, and an enquiry was held at once by the Prison Commissioners. The first of the two prisoners at first stuck to his original story, but later admitted that he had been assaulted. The four officers were then suspended, placed under report and their defences heard by Mr Paterson. He ordered them to be dismissed and later I received a reprimand for not at once reporting all the circumstances to the Prison Commissioners.

The sad thing is that those four officers were among the best officers in the prison, and I was very much

upset by the way they had been treated. The only consolation was that I was able to find them all good jobs with a firm outside the service (62).

Guy Richmond, a P.M.O. at Dartmoor and Portland in the 1930s described in his autobiography some of the major issues around the job at this time. When he joined the P.M.S. in 1930 he had a number of misgivings:

..... What might be the long-term effect of work in a repressive, authoritarian, punitive environment with constant exposure to depressed, hostile and aggrieved individuals? How was it possible to adhere to the Hippocratic obligation of the physician in the face of confinement, and punishment? Also, should a doctor participate in capital and corporal punishment, solitary confinement and other indignities which a prison regime inflicts on its inmates? How much freedom remained for a doctor in his practise while subordinate to a prison administration? (63).

Having satisfied himself that he could cope with such problems he completed his training at Wormwood Scrubs and then moved to Dartmoor, "the toughest prison in the toughest place" (64). Richmond indicates that the P.M.S. was still rudimentary as there were no antibiotics, no general hospital for referrals, no consultants and no laboratory. Additionally, medication took the form of aspirins, iron tonics, cod-liver oil and laxatives:

Tranquillizers were as yet undiscovered and barbiturates were not used; the only sedative prescribed was potassium bromide. To discourage those we thought unnecessarily eager for medication there was a mixture containing a pungent drug called asafoetida. The idea was that the drug was so unpleasant to take, and the breath of the recipient so repugnant to his neighbours that he would cease complaining. This is a form of treatment which would be wholly unacceptable now (65).

He contended that in spite of the basic nature of medical treatment, there were no natural or unnatural deaths in the prison.

Richmond also indicated how troublesome prisoners were controlled and the practical and symbolic role that the P.M.S. played in the process:

A significant proportion of the inmates of Dartmoor would now be classified as psychopathic, but they did not slash or hang themselves or take drugs. They were indeed a disciplinary problem but the prison hospital was large enough to accommodate many of them ..... In the prison hospital there was a relic of a form of treatment which used to be meted out to prisoners who became violently hysterical or maniacal. It was in the shape of a small cabinet, about the size of a telephone booth. On the roof of the booth was a tank of water with a valve attached and a chain like that of a "water closet" tank in England. The unruly occupant was deluged with cold water when the chain was pulled.

When an inmate had to be forcibly fed we did not use a nasal tube or intravenous fluids; the doctor spoon-fed the man, who was gagged, with porridge mashed up with other nutrients. Not once did I find this to fail. Looking back on such a procedure I shudder to think of what might have happened if some of the food had gone down the trachea, though even with modern techniques it has happened that a nasal tube has been pushed erroneously down the trachea and the fluid poured down has suffocated the patient.

It has become increasingly common in prisons to dole out a great deal of medication. Careful precautions have to be taken to prevent the recipients from saving it up so that when it is consumed there will be a worthwhile "kick"; this of course mainly refers to pain killer, sedatives, tranquillizing and mood elevating drugs. At Dartmoor, during the period of which I am writing, on the few occasions when it was necessary to use a narcotic drug such as codeine or even opium, it was considered safe to leave three or four doses of the medication in an inmate's cell to be taken at prescribed times, and the practice was not abused (66).

As I showed in Chapter 3, these developments and debates were to continue into the 1940s and 1950s. The power of the medical profession increased sharply during these decades on the back of the social reconstructionist ideology of the time. Medical

intervention into the social body was increasingly formulated, implemented and legitimated by the state, particularly in its role of welfare protector of the nation's physical and psychological health. Prison doctors and psychologists were beneficiaries of this ideology as they expanded their influence through formal means such as the 1948 Criminal Justice Act and through informal mechanisms such as conferences and research papers in which they claimed expert status in the search for the causes of crime. However, that expansion, as I noted, was not without its own contradictions, limitations, challenges and rejections. Not only was medical hegemony incomplete but such challenges were integral to the sense of crisis in the P.M.S. in the late 1950s and early 1960s which led to the establishment of, and report by, the Gwynn enquiry in 1964. As Chapter 3 also illustrated, the enquiry failed to analyse in any depth the problems of the P.M.S. at the time. These omissions were compounded by the lack of analysis of the issues around discipline, regulation and control which, as I indicated in Chapter 4 have a long institutionalised history in prison medical practice. That disciplinary concern, shaping policy and practice to the needs of the institution, was not a medical conspiracy. Such a reductionist view neglects and negates the complex processes which were at work through the nineteenth and into the twentieth century. At the same time, the doctors, hospital officers, nurses and increasingly psychologists who practised behind the walls brought to their work a set of ideologies which saw the prisoner as an individual, as one who needed or deserved some form of disciplinary treatment. This was particularly true for those who refused to accept the 'normality' of prison life, and who

questioned the wider structure and order of the regime. The problem of deviance in David Garland's words had increasingly become one of "individual pathology and responsibility" (67). The normalisation of the individual, therefore, became the goal of the institution and those who staffed it. In that sense, the individual prison worker was at one with the disciplinary goals of the institution. Howard Jones expressed something of this notion in 1965 in his book Crime in a Changing Society. While he noted that the prison doctor was a trained medical practitioner he was also a:

prison doctor sharing something of the culture and values of the prison with other kinds of prison official. A prison chaplain is no less sincere a Christian and no less hard-working a minister because he is employed in a prison, but one is conscious in talking to him about his work of some elements in his attitude to the men who form his congregation which unite him more with, say, the governor and his assistants than with clergy outside. The modern prison, especially the training prison, uses more and more specialists, for training, supervision of work, education, group work, social case work, etc. Many of them have to find a place for themselves within the prison world. Like the chameleons we all are, they take on the colouration of their surroundings. The adjustment is always to the prison system, never in the other direction, because the individual comes into the system alone and unsupported. It has become, as a result, inbred and conservative. It never has to face a real challenge from outside; when challengers arise they are absorbed, and eventually become 'adjusted' (68).

The timing of this comment is important. It is precisely at this historical moment that the struggle to maintain the social order of the prison becomes significantly intensified. In a decade which saw the emergence or re-emergence of a range of social movements that challenged dominant notions of order and authority, the prison system was not immune from these challenges. As the

crisis of containment deepened (69) so the work of prison medical workers came into sharp focus as prisoners and prisoners' rights groups highlighted the often controversial role that medicine was playing in the struggle to maintain order. Once again, the processes of individualisation and classification were key medical weapons in this struggle. As Stan Cohen has pointed out, classification provides the central link between the nineteenth and twentieth centuries, the continuing emphasis on finding the individual or group responsible for disorder, labelling and removing them from the general population:

If only those who mess up the regime could be weeded out (sent to special prisons, units or isolation centres) the system could go ahead with its business. All that has changed over the last century is the basis of the binary classification. It used to be 'moral character', sometimes it was 'treatability' or 'security risk' now it tends to be 'dangerousness' (70).

### Disciplining the Disorderly: From the 1960s to the 1980s.

In Chapter 3, I indicated how, in the early 1960s, the government opened security wings in order to "cope with what it took to be a new breed of 'violent and dangerous' criminals" (71). This development was to symbolise and illustrate the direction of penal policy throughout the next two decades. Security was increasingly the driving force behind penal policy. It was, in turn, underpinned by an intensification in the struggle to maintain order, especially in the long-term prisons. Before considering the dimensions of this struggle, and the role of

medicine and psychology within it, its is important to recognize that both developments took place against the background of a major increase in the long-term prison population. A range of commentators have pointed to this increase and the acceleration in the population of long-termers from the 1960s (72). Stan Cohen and Laurie Taylor have argued that all the prison statistics lead to the same conclusion. They "document the rise in the long-term prison population and the continuing predilection of English judges, to hand out longer and longer sentences" (73). This trend accelerated through the 1970s and 1980s so that by 1985 "more than a fifth of the adult male prison population" were long-term prisoners (74). Within this population there were specific groups whose sentences added to the increase. Those sentenced in connection with political violence in the North of Ireland was one such group. By 1980, over 40 of those sentenced in England had received sentences of either life or twenty years or more. Another 40 had been sentenced to 10 years or more with "only a handful [being] sentenced to less than ten years" (75).

The number of life sentence prisoners also increased dramatically between the 1960s and the 1980s. In 1957, the number of male lifers was 140, by November 1986, this figure had increased fourteen fold to over 2,000 (76). For women prisoners, there was a similar trend, the number of lifers increasing from 7 in 1957 to 57 in 1986 (77). Life sentences were increasingly being used for offences other than murder. In February 1980, there were 20 such offences ranging from murder through to grievous bodily harm and using firearms to resist arrest (78).



By January 1983, 77% of male lifers had been convicted of murder, 11% of manslaughter and 12% were sentenced for other offences. As the Prison Reform Trust has pointed out:

while the growth in the lifer population is largely due to the increase in receptions of convicted murderers, the wider use of the life sentence for offences other than murder or manslaughter has made a significant contribution to the numbers (79).

By February 1988, Home Office figures indicated that the average sentence for life sentence prisoners was 10 years (80). These processes were compounded by the number of prisoners serving sentences that carried minimum recommendations attached by the trial judge. Between 1964 and 1987, 244 sentences with minimum recommendations were passed by the courts. In only 7 cases were individuals released before the minimum time expired (81).

The build-up in the number of long-term prisoners was accompanied by a major increase in the security and control aspects of the prison system. This development was not new but had its origins much further back in time. As this chapter has already indicated, prisoners were subjected to different forms of control from the turn of the century, including strip-searching, dispersal, the use of escape lists and in 1913 as Arthur Harding indicates, wearing "a parti-coloured dress of yellow patches and brown on his convict suit" (82). By the mid-1960s, following escapes by Ronald Biggs, Frank Mitchell and George Blake, the Labour government intensified these processes still further by adding a number of new dimensions to the policy of internal security and control. These dimensions were based on the recommendations

made by the Mountbatten Committee in 1966 and the Radzinowicz Committee in 1968. Mountbatten's report written in 42 days, in the panicked aftermath of the escapes was in MP Leo Abse's words "a grim defeat" for those who wished to see a therapeutic regime introduced in prisons. Abse describes the direction of Mountbatten's thinking:

.... physical defences had to be strengthened against enemy attack from outside. Horizontal barriers such as barbed wire, together with moats were needed; concrete stubs arranged in series around outside walls should be erected to act as barriers to attacking vehicles; walls should be high and smooth; early warning systems, including geo-phones to detect ground movement were required; ultrasonic acoustic radar could give perhaps too many false alarms but ideally each cell should be designed as a separate unit mounted on pressure transducers virtually converting the cell into a weighing machine giving built-in alarms if the prisoner without authorization left his cell; electric capacity or contact devices and the use of bandit glass sandwich windows were needed; hot air systems to blow away fog at the foot of outer perimeter fences were essential. And a new fortress, the first of two, to incarcerate what were to be described as Category A prisoners was to be built on the Isle of Wight. A totally uninhabited island off our coast would be preferable like the Calf of Man or Muck Island, but reluctantly the Admiral conceded this might make for staffing difficulties; and he had to be content with Spithead and the Solent as providing further barriers to a getaway of prisoners. The Admiral, as Governor of the Isle of Wight, meticulous to the last detail, announced with evident relish that the fortress should have, as indeed it deserved, as a nostalgic name, 'Vectis', the old Roman name for Wight (83).

Abse was to campaign successfully against concentrating top security prisoners in a one-off prison and as a member of the newly created Advisory Council on the Penal System he was to play a leading role in the rejection of concentration and the introduction of dispersal prisons for long-term male prisoners. On the other hand, a number of Mountbatten's recommendations

around security were introduced. These included a formal security classification system that ranged from Category A to D. For those in the top security Category A, tight restrictions were placed on their movements. Alastair Miller, a governor in the prisons at the time, described how, in the summer of 1969, an order was issued by the Home Office stipulating that all visitors to Category A prisoners would need to have a photograph taken which would be checked by the police and "the person would have to report to the police for identification" (84). Additionally, he was to place Category A prisoners in reinforced cells to guard against possible escape attempts. A number of other measures were introduced including cell searches, strip-searches, changing cells, transfer to local prisons under C I 10/74 which meant virtually solitary confinement for 28 days and in some cases the denial of educational facilities (85). Photographs were taken one of which was placed in a small hardback book that recorded every movement the prisoner made. It was to be carried by the prison officer who escorted the prisoner "even to the toilet" (86). Police officers interviewed potential visitors who carried a book with a photograph which they produced when visiting. The prisoner's mail, instead of being handled by the prison censor was "now re-channelled to a special security guard and because of this my mail is regularly held up and suppressed for security reasons" (87). Those convicted of political violence in connection with Ireland were held on "Special Category A". At Wormwood Scrubs they had "closed visits":

There is a sheet of glass between the prisoner and his visitors; and there is a little speaker grill cut out in the glass. It is only possible to communicate by talking loudly and of course the warders are within ear-shot. Such conditions are hardly conducive to family conversation. These closed visits only apply to Irish category 'A' prisoners, the ordinary English category 'A' prisoners have normal visits.

John and his family made numerous complaints to all kinds of people about these visiting conditions. But it was all to no avail. They received the impression, later to be confirmed, that the prison governor was acting on specific instructions from the British Home Office on how Irish prisoners' visits are to be conducted. Even though the visits were 'closed' with no possibility of bodily contact or passing anything through the glass, John's wife was always searched thoroughly beforehand and checked from head to foot with a metal detector. Apparently just harassment, as usual (88).

By 1983, Home Office research revealed that those on Category A fell into 4 major groups: 40% were professional criminals, 30% had been convicted of political offences usually associated with Ireland, 20% had committed sexual offences and the remainder had been convicted of murder, manslaughter or serious assault (89). In January 1984, there were 250 male prisoners on Category A, over 4,800 on Category B with those remaining classified under Categories C and D (90). This emphasis on security and classification had a major impact on the prison system, it percolated through the penal estate underpinning, directing and dominating penal policy in both long-term and short-term prisons. Between 1962 and 1977 there was a 5,833% increase in maximum security places compared with a 41% increase in long-term prisoners in the same period (91).

Despite this massive increase in security, problems of internal control not only remained but substantially increased from the

late 1960s. Through the 1970s and into the 1980s there were major demonstrations in the majority of the long-term maximum security prisons. Between 1969 and 1983 there were 10 disturbances alone (92). Significantly, these problems were blamed on a small number of difficult, subversive prisoners who manipulated an otherwise quiescent prison population into riot and demonstration (93). These prisoners were regarded as a new breed, more recalcitrant and subversive than anything previously known. This official line of analysis according to Roy King happens:

I suspect, regardless of whether long-term prisoners are more dangerous and more troublesome than they used to be. We are dealing with perceptions of changes, rather than, or as well as, the changes themselves, and the perceptions become the main-spring for action in Prison Department policy (94).

King goes on to point out that this view is not only erroneous but self-defeating:

Probably the most widely held view, both inside and outside the Prison Department, is that the worst control problems have been generated by comparatively few peculiarly difficult, recalcitrant and dangerous prisoners, some of whom may be psychologically disturbed. These prisoners are typically thought of as including terrorists, strong-arm men and leaders of criminal gangs, serving very long sentences of imprisonment; men who are as dangerous inside prison as they are outside ..... It would be irresponsible and naive to deny that such men exist. Of course they do. But I do wish to argue that conceptualizing the control problem as the product of 'difficult' or 'disturbed' individuals, and developing a reactive policy towards them, has been both partial and self-defeating. Partial in that it ignores all the structural, environmental and interactive circumstances that generate trouble, reducing it to some inherent notion of individual wilfulness or malfunction. Self-defeating in that the policy itself becomes part of those very circumstances that generate the trouble:

it is likely that among those who get defined as troublemakers there are some who are made into troublemakers as a result of the way they are dealt with in prison, just as there are some who come to prison as troublemakers (95).

Despite such views, the managers of the system have concentrated their efforts on a range of policies designed to individualise and isolate the prisoner or prisoners responsible for riot. The prison doctors themselves had identified the existence of such a group around 1965. In a memorandum to the Royal Commission on the Penal System, (established in August 1964 but abandoned without reporting within 18 months), they argued that:

In view of the increasing number of difficult and disturbed inmates in Prisons and Borstals we believe that the role of the doctor is of increasing importance in penal treatment and furthermore we consider that medical opinion should be represented in policy making on the Prison Board (in the person of the D.P.M.S.) as, until comparatively recently, it used to be represented by the Medical Commissioner on the former Prison Commission (96).

In 1970, the Chairperson of the Prison Officers' Association talked of the "sophisticated, dangerous, psychopathic villains who make full use of the misguided and the inadequate to achieve their own evil ends" (97). The previous year the Home Office maintained that "there will always be a small minority of offenders needing strict control and supervision." Such prisoners it was felt, if given "any opportunity to do so will dominate the larger group of which they form a small part" (98). The ex-prison governor, Alastair Miller pinpointed the "disastrous effect that some wicked men can have on the morale and well-being of their fellow-prisoners hundreds of whom are fully co-operative" (99).

In 1972 there were demonstrations at over 100 prisons (100). Robert Carr, the Home Secretary, responded in May 1973 by announcing a number of measures designed to improve "our facilities and techniques for containing violent and dangerous men in prison" (101). These changes included expanding the number of dispersal prisons to nine (there were then six) and to build segregation units in each of them. The demonstrations had come on top of a major disturbance in Parkhurst in 1969 and were to be followed by an attempted break-out and trouble at Gartree in November 1972. Against this background Carr announced the establishment of:

two additional facilities for dealing with the small core of intractable troublemakers. Two control units would be set up in existing separate accommodation within the present dispersal prisons to accommodate such 'thoroughly intractable troublemakers' (102).

The Home Secretary had established an eleven person Committee of Inquiry which was chaired by W.R. Cox of the Prison Department. The Committee produced a 20,000 word report which "was never published and even the governors themselves were refused permission to see it" (103). The report claimed to have pinpointed a rise in "anarchist attitudes" in the prisons. Additionally, there were "72 particular trouble-makers in the system, many of them young men serving long sentences ....." (104). After an internal bureaucratic battle, the Home Office established the Control Units. Details for implementing the Units were contained in Circular Instruction 35/1974 circulated on 17th June 1974 "and approved by the Secretary of State though it was not sent to the

House of Commons and consequently Members of Parliament remained ignorant of any details of the regime" (105).

The Unit at Wakefield was opened on 1st August 1974 and three prisoners were received on the 23rd of the same month.

There was a fourteen page supplement known as Annex D to CI 35/1974 Notes for Convicted Prisoners in Control Units (Cell Information Card). Paragraphs 1 and 6 were blunt:

You have been brought here because it is considered that you have been disposed deliberately to try to undermine and disrupt the pattern of life in the prison from which you came and have shown by your behaviour that you were not prepared to co-operate with the normal prison regime .... If at any time you fail to co-operate, to work satisfactorily or to behave yourself you will move back to the beginning of Stage 1 and have to start all over again (106).

The regime was based on sensory deprivation. There were no windows in the cells and "no noise could be heard within them":

White light was continuous and inside they were painted brilliant white. Prison officers who manned these cells were given special training in avoiding any personal involvement or conversation with the prisoner. Officers were equipped with special footwear so that they made no noise while approaching the cells. Over a number of meetings, a list was drawn up by the Home Office and the prison administration of those prisoners who they felt represented the most difficult management problem. The prisoners, once in the cells, were presented with a rigorous behaviour programme. They were placed on a graduated scale of privileges which they could 'earn' during successive ninety-day periods. If at any time they 'misbehaved' or were put on report, they reverted to day one of the scale and had to begin again. The point of the experiment was to break the will of recalcitrant prisoners (107).

John Masterson, one of the prisoners detained in the Unit at



Wakefield, described the psychological pressure put on him while there and the "head game tricks" which were utilised:

If you did ask a question they just blanked you, as if you were mad. Just stared past you or went into the Home Office stance as I call it - sticking their chests out, heavy breathing, legs apart. This was all for the psychological effect when you got back in the cell. Then you started tearing your mind apart. There was a particular screw, I found it unusual, that wore hobnailed boots. Any time you walked anywhere, he used to crash his boots behind you. Banging his feet down hard and all that. Yet other times, if they didn't want you to hear them coming to your door ... They used to have a screw there, whether he was instructed to do it or not - he must have been because it would drive anybody up the wall - whistling, you know that right piercing whistle all day long. I don't know how he could keep it up. It must have been doing everybody. I know it was doing my head in because one day I jumped up and I crashed the chair against the door.

The first time I went into my cell, there was a few sheets of paper on the bed, typed, it said, 'Control Unit, you are now on Rule 45 ...' I'm not thick, I know what control means, to control anything you're in charge of it and to be in charge of a human being you've got to be inside his mind. So right away this is what made me realise what they were doing was psychological warfare (108).

The use of such individualised, psychological techniques did not have complete support from the prison doctors. David Leigh for example, details how Dr Topp, a Principal Regional Medical Officer:

recorded his alarm. He feared that psychopathic people would end up by behaving worse under such conditions: 'Segregation in this way will rapidly become intolerable to them.' A crushing reply came to him from the Home Office saying: 'You are inevitably unaware of the arguments and reasoning which have preceded these decisions' (109).

In April 1975 he sent a:

prescient 'private and confidential' note ... to the joint ethical working party of the Royal College of Psychiatrists: 'the whole exercise so far has largely proved a non-viable proposition ... of little practical use to the system and besides which, a rather politically unacceptable concept .... left alone, the whole situation will die a natural death' (110).

On the other hand, as Martin Wright indicates, when he visited a prisoner in the Unit at Wakefield he was shown the record of one "who had refused to speak to the medical officer: his offence was described in a phrase with a mediaeval ring, 'mute of malice'" (111).

#### Managing the System.

The controversy surrounding the Control Units and the sensory deprivation involved, was part of the debate around managing the increasingly fragile order of the prison. That order was threatened not only in Western Europe, but as Chapter 3 indicated, in American prisons as well. In the summer of 1973, David Cooper, the M.O. at Parkhurst, wrote an article in the Prison Medical Journal describing his visit to a number of prisons in North America. He identified the problems confronting the American system. These included: changes in the attitude of prisoners to authority; the fact that intelligent sections of the community were bent on pulling down or destroying the prison system (112); "changes in the prison population itself with an increase in young aggressive individuals and a rise in the number who are mentally disturbed in some way" (113). As for the system in England and Wales he predicted a decrease in

the prison population which would leave behind a body of long-term prisoners who:

will be more disturbed and less likely to co-operate. This will lead us as doctors to taking a greater part in their management and co-operating even closer with other sections of the prison management team. Those working in prisons will be under an increased threat by prisoners both physically and by litigation and subjected to severe criticism from pressure groups in society .... this in turn will lead to the establishment of specialised units designed to cater for the management problems of individual groups of prisoners and their specific needs (114).

As I shall indicate, Cooper's prediction about the falling prison population was to prove false. However, he was to prove correct on the question of the relationship between the P.M.S. and the management of the system. From the point of view of those in the long-term prisons, the doctors were indeed part of the management structure, but it was a structure that denied and indeed individualised what they regarded as legitimate grievances concerning the philosophy and practice of long-term prison regimes.

Through the 1970s and 1980s the management of the system took different forms and followed different policies. They were linked however, by the umbilical cord of individualisation, identifying those deemed to be responsible for the trouble and disciplining and isolating them. A number of strategies were involved in this process including segregation. While the Control Units were officially phased out in October 1975 they were:

not to be dismantled as such, but reserved for those prisoners who had to be removed from the rest of the

prison population 'in the interests of good order and discipline'. Not surprisingly, perhaps, this announcement left some groups in the penal lobby wondering whether they had simply won a battle but lost a war. Discipline through segregation was still officially favoured and who could be sure what this might mean in the future? (115).

Mick Ryan's question was to be answered by prisoners who described the segregation techniques that were utilised. After protesting about visiting conditions in Albany, Raymond MacLaughlin was moved to Wakefield's 'F' Wing in 1979 where he was held in:

the control unit for three months. When he was removed from it he was completely dis-orientated and had lost all track of time. For a time afterwards he suffered from dizziness and inability to speak properly (116).

In his autobiography MacLaughlin described a further spell in 'F' Wing when he was transferred there after a major disturbance at Albany in 1983:

It was designed for maximum isolation. For example, the windows are about three foot deep, two foot wide and one foot high, made up of three inch square tiles of frosted glass. There was no glass in two of these tiny squares and that doubled as my source of fresh air and my view. This view consisted of the twenty foot white wall that surrounded the unit. This wall was painted with abstract lines of the most dismal colours, i.e., grey, dark green, and black. The official explanation for these abstract designs was that the exercise yard that ran between the white wall and the unit was so narrow, that the designs helped give the illusion of more space!! (117)

The use of segregation did not defuse the problems in the long-term prisons. In 1975 Irish prisoners caused £25,000 damage to

the roof of Wormwood Scrubs. In September 1976, there was trouble at Albany when six Irish prisoners erected barricades in support of one of their number who had been placed in the punishment block for refusing to clean his cell. There were claims, partly endorsed in a joint report compiled by Amnesty International, the National Council for Civil Liberties and the Howard League that prisoners had been assaulted (118). In the same month there was a major disturbance at Hull prison which lasted for three days. In the aftermath of the disturbance prisoners, particularly those who were Irish or black, were subjected to violent abuse by prison officers. In January 1979 twelve prison officers and an assistant governor were tried at York Crown Court for their part in these events. The judge and jury heard from a "procession of prisoners":

One told how a jug of urine was poured over him, others described how they were pulled along by the hair or were beaten on the way to being transferred. Many prisoners, in their evidence, observed how the IRA and black prisoners were especially humiliated. One of the former, for example, was made to sing 'God Save the Queen.' This man was held down and told to sing. He replied, 'Go play with yourself, you puff' [sic]. An officer then said, 'Hold his legs open', and then 'he put the boot in my testicles'. Later he was told, 'You Irish bastard; you'll remember me for the rest of your days.' One of the black prisoners stated that he had been kept awake on the night of the surrender by officers switching on his light, kicking his door and shouting: 'National Front rules, big black bastard.' After being beaten, this prisoner went to breakfast when an officer said: 'What does this black bastard think he is going to get?' When he did get breakfast, another officer hit his hands and the food went all over him. After being made to run the gauntlet to 'see if you can run like the other black athletes' he was put in his cell. There another officer poured the contents of a chamber-pot over him.

The other black prisoner had the same kind of treatment. He was the man that the PEI had failed to knock down, and he confirmed Unwin's version of this parti-

cular assault. He also alleged that an officer had said: 'You flash cunt. If you're not quick with this slopping out, you'll be a sorry nigger' (119).

Eight of the officers were found guilty of conspiring together with others to assault and beat prisoners (120). They were all given suspended prison sentences one of which was overturned on appeal. The prisoners raised a number of specific issues regarding the P.M.S. They complained about the lack of medical treatment after the beatings (121). They also maintained that they could not report sick. To do so would have risked being labelled as a malingerer (122). There were further disturbances at Gartree in October 1978, at Parkhurst in March 1979, Hull in April 1979 and Wormwood Scrubs the following August.

This last disturbance was notable because of the intervention of the Minimum Use of Force Tactical Intervention Squad (MUFTI). The squad was trained in riot-control and developed out of a working party established in 1978 "to give guidance to prison governors on the minimum use of force, tactical intervention ..... following serious disturbances including that at Hull prison in 1976" (123). Although it had been in action prior to August 1979 it was the squad's intervention in that month at Wormwood Scrubs which brought it to public attention. On 21st October after a number of prevaricating statements by the Home Office concerning the injuries prisoners had sustained, Christopher Price MP elicited from Ministers statistics which indicated that a total of 54 prisoners "incurred injuries consisting of cuts, bruises and abrasions. Eleven prison

officers incurred similar injuries" (124). The Prison Medical Service came in for particular attention in relation to how the prisoners were treated after the disturbance. The National Prisoners' Movement (PROP) provided a commentary on the official inquiry into the disturbance (125). PROP argued that the inquiry highlighted some serious deficiencies in the Service's response to the injured:

At the regular Board of Visitors meeting on 5 October, six weeks after the event, the PMO reported that "four or five prisoners had required sutures for head injuries out of a total of 55 prisoners reporting sick". Pressed for more details the PMO "left the meeting to check his figures" before giving "a revised set of injury figures" which included 16 prisoners sutured. As the Report makes clear, none of the figures were accurate.

A member of the Board of Visitors (not the Chairman) later went to the prison hospital and asked to see the Reporting Sick Register. She was told by the PMO that he would have to seek authority before complying with her request, and he repeated this when she pointed out her entitlement under the Prison Rules to see the medical records as a member of the Board of Visitors.

She did eventually get to see the records but "it required a great deal more pressure than she had ever known before" (126).

Kay Douglas Scott described her visit to one prisoner. She told Granada's World in Action she was:

really shattered by his condition. He had stitches in his head, arm .... and he limped very, very badly ... he was made to walk down ... four flights of stairs ... to the ground floor where two hospital officers sutured his head .... After they put the stitches in, his head hurt considerably. They neither offered him or asked him if he wanted any pain killers of any kind (127).

Dr Eric Beck, a consultant physician at Whittington Hospital in

London did not treat any of those hurt but after studying the Home Office report into the incident, noted that 19 prisoners required stitching (128). He told the programme he was:

particularly surprised to see that the stitching was done by prison hospital officers without the injured prisoners being seen by a doctor first. And this is completely at variance with any practice in the National Health Service. The whole area about stitching by nurses ..... is very carefully laid down that it can only be done after a patient has been examined by a doctor who then may authorise a nurse, who will have had to have had at least three years experience, be a state registered nurse, unlike the prison hospital officers who may have had as little as three months medical training of a sort of first aid nature, and I think there is considerable potential hazard in this being carried out in this way (129).

Alistair Logan summed up what he saw as the central issue involved pointing out that the P.M.S.:

is not there to serve the prisoner it is there to serve the prison service. Many of the people working in the field have a great deal of sympathy and competence. A lot of them I believe do not have as much competence as others. However, anybody who has worked in connection with prisons for any length of time realises that a good number of them believe that their first duty is to the prison medical service, and the prison service, and their second duty is to the prisoner (130).

The development of the MUFTI squad, was, despite this controversy, to continue in the 1980s. The squad's protective clothing itself developed from the experience gained by the police in disturbances at Toxteth, Moss-Side and Brixton. This experience was used by the Scientific Research and Development Branch of the Home Office which assessed different kinds of equipment and concluded it could utilise the protective equipment the police were using and offer



it to the prison service. From the early 1980s a number of prisons trained their officers in these tactics. When the Chief Inspector of Prisons inspected Winson Green in November 1981 he found that 16 principal, 30 senior and 146 basic grade officers had received basic MUFTI training and there had been some refresher courses (131). It was also noted that 30 full sets of protective clothing were held in the prison and that "trained staff were available to be deployed to any Midland region establishment in the event of an emergency" (132). At Featherstone, 16 sets of equipment were stored but no refresher courses had been held for staff. The Chief Inspector reminded the governor of the need to "recommence training of all staff in the use of MUFTI equipment as soon as possible and for regular refresher training to maintain adequate standards" (133). The Home Office noted that:

the effect on the morale of would be rioters on seeing a disciplined formation of officers in matching protective equipment should not be underestimated. This uniformity will add significantly to the professionalism and confidence of the prison officers taking part (134).

The North Region Training Programme for 1984-5 gives some indication of the direction of MUFTI policy. Its aim was to "train all staff in the basic skills of Incident Control in accordance with the H.Q. memo." The contents of the course included:

... understanding the need for training ...  
awareness of its value in any serious incident  
..... Knowledge of the equipment to be used  
... acquire the ability to act as a disciplined  
body in an incident situation (135).

James Campbell's conversations with prison officers and prisoners, published in 1986 under the general title of Gate Fever, provided an insight into how the prison officers saw the role of the MUFTI squad in particular and discipline in general. He discussed with one prison officer why he had refused to take part in the training:

'I'd need to be sure I wasn't going to be prosecuted afterwards if I hit somebody too hard, or if I killed someone. If you go into a situation such as that training is designed for, there's no use giving a little hit here and little hit there, as the Home Office suggests; you have to get the adrenalin going, don't you? You have to get wound up a bit, give it a hundred per cent. If they give me a stick and put me in the front line and then some fellow comes at me waving a broken half of a strip of neon light, I'm not going to tap him politely on a vulnerable spot, am I? No, I would need to have it down in black and white that I wasn't going to be prosecuted for that kind of thing' (136).

The development and deployment of the militarised MUFTI squad, and the medical controversy it provoked was paralleled by the ongoing controversy over the use of drugs as a mechanism for control. As Chapter 3 indicated, the prison doctors were remarkably frank in the late 1950s and early 1960s about the impact that drugs had on their ability to control difficult prisoners. When in 1963, the Home Office took responsibility from the Prison Commissioners for the administration of the prisons, the tone of the official reports changed. There were no longer long unsigned statements from doctors, psychologists and chaplains discussing their role inside. Instead, the public was given the 'facts' about the prison service and little else. This itself was paralleled by accounts coming from the prisons about the use of drugs in a number of institutions. The formation

of Radical Alternatives to Prison in 1970 and the National Prisoners' Movement in 1972 provided a forum for prisoners to articulate their grievances. As the crisis of containment deepened so the allegations became stronger that drugs were being used for disciplinary purposes.

### The Politics of Drugs.

The use of drugs in institutions was not a phenomenon that emerged in the 1950s. Prisoners in the nineteenth and early twentieth century described what they termed 'sleeping draughts' to alter behaviour. What was different in the 1950s was the manufacture on a large scale of powerful new combinations of chemicals involving multi-national companies. Chlorpromazine (marketed in Britain under the trade name of Largactil) is a good example of this process. When introduced in 1954, it had been tried on 104 psychiatric patients in America. A year later, it was being administered to two million people alone in that country. For the manufacturer, Smith, Kline and French, the commercial impact was equally great. Within a year of its commercial introduction, "Largactil had increased the company's total sales volume by one third. Between 1957 and 1970 net sales increased from 57 million dollars to 347 million dollars" (137). As I indicated in Chapter 3, the doctors were quick to praise the potential of these drugs for controlling difficult prisoners. Their accounts, dating from the late 1950s and early 1960s, were supported by accounts from other sources. These became particularly important from the mid 1960s when the official Prison

Department reports, as I have noted, changed style and placed further restrictions on the quality of information coming from the prisons.

In his account of the Great Train Robbery, Piers Paul Read described life for the men in Parkhurst security wing in 1966 where "those whom this living entombment made frenzied were quickly dosed with Librium and Valium" (138). Wally Probyn, who was in the prison at the time described the case of a prisoner who:

attempted to cut his own throat shortly after arriving at the block. Ted had no one in the outside world to care about him or to protest on his behalf, so he was an ideal subject for experimentations. Despite Ted's chronic depression, which was caused by the oppressive and claustrophobic conditions of the block, he was coldly observed and recorded. Ted remained in his cell most of the day and night. He was taking powerful drugs that sent him to sleep all the afternoon and another dose that sent him to sleep all night. He became totally dependent on the drug and on the one occasion that it wasn't readily available, he became extremely distressed and began pleading and threatening until it was at last produced.

Ted became more and more like a zombie over the months. By the time he was moved (to where, no one knew or yet knows), which was about fourteen or fifteen months later, he was just a human wreck. His eyes were lifeless and vacant, it seemed amazing that he still lived at all. Ted was just one of the casualties of the programme for new psychological control of prisoners (139).

In his autobiography, Alastair Miller, the ex-governor of the prison also discussed the regime in the 1960s. In the case of an "aggressive psychopath" who assaulted another prisoner:

He had to be restrained. He was extremely violent and would have damaged anyone in sight. He was firmly dealt with and was hit during the restraining. This brought him to what sense he had. The member of staff who hit him reported this to higher authority. While in the cells he was constantly under sedation and under the Medical Officer's supervision (140).

As in the 1920s and 1940s concern about the situation led to the formation of a pressure group to highlight the issues involved and to challenge the involvement of medicine in the process of discipline and control. In November 1977, the National Prisoners' Movement initiated the formation of the Medical Committee Against the Abuse of Prisoners for Drugging. The Committee was made up of representatives of the National Prisoners' Movement, the National Council for Civil Liberties, the National Association for Mental Health, the Standing Council on Drug Abuse, Radical Alternatives to Prison and Release. A number of consultant psychiatrists were also involved as well as David Markham, the Chair of the Bukovsky Committee and Victor Fainberg, the Chair of the Campaign Against Psychiatric Abuse. Its purpose was to monitor the allegations that were emerging and to "campaign for the dissolution of the Prison Medical Service and its replacement by a health service for prisoners free of Home Office control and administered, instead, by the NHS" (141).

The controversy was compounded further in the autumn of 1978, when it was revealed that a prison doctor had written an article in the Prison Medical Journal which concerned the treatment of psychopaths with the drug Depixol. According to the doctor:

For some years we have had the problem of containment of psychopaths who, as a result of situational stress, have presented the discipline staff with control problems for which there has been no satisfactory solution ... From a medical angle these men show no evidence of formal illness as such, but, clearly, are characters having a lot of nervous tension, a certain amount of depression, considerable frustration with a low flash point who, until the situational stress can be removed or modified, are potentially either very dangerous or in the case of the more inadequate, an unmitigated nuisance (142).

He added that these men "are considered by the governor and discipline staff as medical problems ... [and were] regarded purely as discipline failures" (143).

From the summer of 1979 through to the summer of 1980, there were a series of Parliamentary questions about the subject. It was revealed that the drug Benperidol had been used on sex offenders by a doctor working in a prison in 1971. While the Committee on the Safety of Drugs had authorised the manufacturer to dispense it on the prescription of any registered medical practitioner, its product licence was not issued until July 1973 (144). Renee Short followed up this revelation with a series of questions. She asked, the then Home Secretary, William Whitelaw, to disclose "the list of drugs, with product licence tested on prisoners in Great Britain." Whitelaw replied in the following terms:

Cyproterone acetate (Androcur) which was granted a product licence in January 1974, was used by one consultant psychiatrist working in prisons between 1970 and 1974. Benperidon (Anguil), which was granted a product licence in July 1973, was used by doctors working in prisons between 1971 and 1973, ..... Both drugs had been used overseas and in the National Health Service before they were used in prisons. I am not aware of any other drugs having been prescribed by doctors working in prisons in England and Wales before they had been granted product licences (145).

These questions also brought into focus the issue of drug treatment and sex offenders. Sex offenders had, as Chapter 3 indicated, been a particular concern for medical personnel in the 1950s. This continued into the 1970s when chemical treatment was used to control their sexual urges. A number of them underwent profound changes. Between November 1975 and November 1978 138 prisoners received one or more types of chemical treatment. Within this group, 15 had operations to remove breasts and two others underwent the operation after their release (146).

Once more, a number of outside commentators focussed on this issue and raised what they regarded as fundamental questions which were relevant to the prisoners involved. In May 1979, contributors to Probe, a journal for probation officers saw the issues in the following terms:

1. What is the justification for this practice?
2. Is it ethical?
3. Is it effective?
4. Can a prisoner truly consent within the constraints of the parole system?
5. Are there sufficient explanations and safeguards for the prisoners?
6. How are prisoners selected for treatment?
7. Is it practical within the prison setting and on licence within the community?
8. What would be the role of the Probation Service in supervising a parolee undergoing drug treatment? (147).

In the autumn of 1981, those working around the group Radical Alternatives to Prison (RAP), also discussed the issue and made it clear that their discussion raised more questions than it answered. However:

we make no apology for that. We, as a group have not solved in our own minds the conflicting ethical and political considerations which emerge from the debate about how we should deal with men whose sexual behaviour is deemed violently dangerous (148).

Despite this, the group was clear about where it stood in relation to the role of the P.M.S. in the whole procedure:

..... we are clear that the present status of the prison medical service places prison doctors in an impossible ethical position in which they are unable to distinguish between treatment and control; we feel that the parole system and the associated pressure put on prisoners by their doctors to accept treatment makes it impossible, to talk of consent to treatment in a meaningful way; and we are totally opposed to the use of prisoners, by unaccountable prison doctors, as guinea pigs, on which to experiment with new drugs and therapies. All this leads us to conclude that a greater degree of independent advice and consultation must be available to men who are recommended for behaviour therapy and drug treatment because they have committed sexual offences (149).

The more general question of the use of drugs for disciplinary and control purposes continued to rumble on. Under pressure, the Home Office released statistics apparently detailing the amount of drugs in prisons. This was first done in 1979 and repeated in 1980 and 1981. Although welcoming the release of the statistics, Radical Alternatives to Prison, in a series of carefully researched briefing papers and articles, illustrated how the presentation of the statistics still left a number of basic questions unanswered. The group made three broad criticisms of the presentation. First, the classification scheme in the Home Office figures between 'Psychotropic drugs' 'Hypnotic drugs' and 'Other drugs affecting the Central Nervous System' was meaningless "without further elaboration from the



Prison Medical Service on exactly what drugs they place in each category" (150). Second, the broad band of categorisation that the Home Office used "disguises the fact that some drugs are far more dangerous than others while falling in the same division" (151). Third, the figures lumped together the number of drugs dispensed in:

two, three and in one case 42 prisons. The explanation for this practice is that in "those establishments in which medical services are largely provided by a single doctor .... it is not considered appropriate to publish information about an individual doctor's prescribing practice" .... Such an explanation typifies the atmosphere of secrecy and the lack of public accountability that surrounds every aspect of the work of the Prison Department. The net result of the Home Office's desire to protect its employees from public scrutiny is that for 90 different penal establishments it is impossible to make accurate and meaningful comparisons between dosage rates (152).

Two significant points did, however, emerge from the release of the figures. In the first place, there was "the enormously high dosage rates for women's prisons, in particular Holloway" (153). This is considered in greater detail in the next chapter. Second, there were wide variations in dosage rates for male prisons. Brixton, a remand prison, had the second highest dosage rate per prisoner while Grendon Underwood, the psychiatric prison recorded the lowest dosage rate of any prison, remand centre or Borstal. According to RAP, Grendon's low dosage rate indicated that there were methods that could be used to deal with those who were suffering mentally without using:

heavy doses of behaviour modifying drugs. If Grendon is able to contain its population without the widespread use of drugs why, then, do other prisons with proportionately far fewer mentally disturbed prisoners

need to prescribe as many as 300 doses of drugs per man per year? It is important to stress that RAP is not saying that there is a 'normal' acceptable dosage rate for our prisons which is being exceeded in some instances. Such a dosage rate is impossible to give. What we are saying is that there are certain dosage rates which cannot be explained by the Home Office's covering statements: indeed some of the dosage rates clearly contradict those covering statements. The Home Office must be pressed to give a fully adequate explanation of their statistical information. At present, the statistics they have provided confuse rather than clarify and beg more questions than they answer (154).

The journalist David Leigh summed up the position at the time:

One favourite Home Office ploy is to assert to journalists and pressure-groups that it will not give details of drugs ordered, or treatment given, to preserve the confidentiality of the doctor-patient relationship. This happens if a prisoner indicates consent for the disclosure; and even in the case of figures of overall drug purchases for unnamed inmates. When a prisoner cannot choose his doctor, and the doctor is forbidden by his terms of employment from talking even generally to the public, it is, of course, mere hypocrisy to protest concern for a prisoner's 'privacy'. The doctors themselves are in the happy position that they are barely accountable to anyone, and if newspapers are incautious in printing allegations, they can sue. Three prison doctors obtained large sums in libel damages from The Guardian following an account it printed in November 1978 of the complaints that John Stonehouse, a jailed ex-Labour minister with a heart condition, was apparently making about conditions at Wormwood Scrubs. Prisoners may be biased and unreliable; doctors can retreat behind a wall of silence; and as Robert Kilroy-Silk, a Labour MP put it in December 1979, 'It is no longer possible to believe statements from the Home Office.' Under such circumstances, truth may suffer but secrecy rebounds. Far from acting as a buffer for the failures of the Civil Service, it gnaws away at public confidence (155).

Barry Leggett made a similar point in Probe:

The Prison Medical Officer in the existing set up inevitably has a dual allegiance not only to those under his care but also to the total institution in

which he operates. This must lead to activities which largely favour the institutions .... under the present set-up it will be very difficult to prove individual allegations of malpractice or detect general trends which conflict with the interests of the prisoner (156).

Leggett also indicated that the continual isolation of the P.M.S. meant that it was likely to be a system where poor standards predominated and which recruited the worst instead of the best categories of staff. He pointed to what for him was an important contradiction in the health care for prisoners. While the 1948 National Health Act stated that every person had the right to choose his/her own doctor:

in contradiction, the Prison Rules of 1964 (rule 17) state that the Medical Officer of the prison shall have the care of the health, mental and physical of the prisoner. To ensure that prisoners receive the best available medical treatment as of right I think it is essential that the Prison Medical Service is replaced by a service which would be accountable to the DHSS and administered within the National Health Service (157).

As David Leigh indicated, the issue of drugs had become so contentious that the prison doctors initiated a series of libel proceedings against newspapers (158), academics (159), magazines (160) and publishers (161). The use of the libel laws, however, did not suppress the criticism which came not only from those outside the prison service but from within the state itself. Benjamin Lee, who was the medical advisor to the Prison Inspectorate before he resigned, outlined his views on the subject in October 1983:

.... that prison doctors have become so sensitive to media criticism that they are just as likely to

withhold doses of psychotropic drugs. It is true, though, that doctors may administer, or countenance the administration of, psychotropic drugs, to achieve what the disciplinary staff want - a quiet prison (162).

In a series of Parliamentary questions in July 1984, MPs Gerry Bermingham and Alex Carlile again pressed for more information on the issue. Douglas Hurd told Carlile that psychotropic medicines could be "administered by hospital officers who do not have nursing qualifications but who will have received appropriate training" (163). Bermingham also elicited the information that 21 prisoners had received electro-convulsive therapy in 1981, 4 in 1982, and 7 in 1983 while during the same period no prisoner had received either sex hormone implants or psycho-surgery (164). Prisoners themselves engaged in litigation. In at least one case a prisoner successfully sued the Home Office after being injected with Largactil without his consent while on remand in 1978. He was awarded £600 "for his hurt feelings" (165). The Prison Reform Trust brought a number of these themes and issues together in their 1985 publication Prison Medicine: Ideas on Health Care in Penal Establishments. In his contribution to the book, Dr Tony Whitehead pointed out:

It would appear that there is evidence that drugs are, at least sometimes, used for disciplinary rather than therapeutic reasons. No doubt such allegations will continue to be denied, but the evidence, though limited speaks otherwise. It also appears that the use of drugs is less prevalent than previously. It would also appear that this reduction in the use of drugs has been a direct result of agitation by certain groups of individuals and, but for that agitation, would not have occurred (166).

Whitehead's statement appeared to receive support from Phil Hornsby, the Assistant General Secretary of the Prison Officers' Association.

In January 1986, he was interviewed on the ITV programme Insiders in which the following exchange occurred:

Interviewer: There is however a fine line between the use of drugs for therapy and their use for control.

Hornsby: Certainly there are cases in prison, quite a lot, where we would suspect drugs have been given to prisoners for no other reason than for control measures, because, quite simply, prison officers do not have the training and the ability to nurse these people properly.

Interviewer: So, in a sense it would be officially therapy of some kind, for medical reasons but the reality is, as it is I would suggest in many mental hospitals, it is to do with control.

Hornsby: Yes, I wouldn't argue against that.

Interviewer: When you were an officer yourself, were you aware, I mean was that one of your impressions from the 11 years that you spent as an officer?

Hornsby: Yes, I mean it has to be said that it is vital for the prison officer to be in charge of the situation in prison otherwise we'd have total disruption and anarchy but how that is best achieved ... with a normal prisoner we do it by the normal methods and there is a normal expectation that people will behave and conform to regimes. With the mentally abnormal offender he doesn't know any better and by hook or by crook he has to be controlled. I'm not so sure that's right, the way we do it (167).

### Disciplining the Majority.

The question of maintaining order in the long-term prisons, and the issues around medicine that flowed from this, was accompanied by the ongoing concern over short-term and remand prisoners and the conditions in which medical treatment for these prisoners took place. As I argued in the previous chapter, medical treatment for the confined in the nineteenth century was constrained and determined by the impact of less eligibility on the philosophy and practice of penology. Discipline and regulation were corner-

stones of penality which in turn meant that the physical conditions were, for many, purgatorial. This discourse, and the policies and practices that were generated continued into the twentieth century. Prison regimes for the short-term confined remained disciplinary in their orientation and philosophy. The conditions in which the incarcerated lived and worked began to decline still further from the 1940s as overcrowding rose. By the 1970s *overcrowding and the often appalling conditions* in which prisoners existed was a *major cause* for concern in the debates around the prisons. At the same time this was a central element in the crisis that gripped the system during the decade (168). Reports by academics, prisoners' rights groups, the media, politicians and prisoners themselves all highlighted the often gruesome and depressing conditions in which short-term prisoners lived. Prison medicine was caught up in these conditions. While the rhetoric of rehabilitation had allowed the managers of the penal estate to argue that prison health care was similar to that provided by the NHS the reality for those behind the walls was a health care system *caught in the disciplinary vice of appalling conditions and the legacy of less eligibility*. The evidence from the Royal College of Psychiatrists to the May Inquiry in 1979 caught the flavour of this inter-relationship:

Since prisoners are already disadvantaged, the facilities available for their treatment should be at least equal to those in the community. However, the high morbidity of those imprisoned, which can be compounded by disabilities induced by the process of imprisonment itself, is met by a general tendency to reject and scapegoat prisoners so that the services provided for them are often minimal.

Difficulties in providing health care reflect the inadequacies of other amenities for prisoners. Over-crowding is a most serious problem and those sentencing must seek alternatives to imprisonment. This would include the provision of better resources within the NHS, but this is unlikely to be realized if developments are in financial competition with other services.

The Prison Medical Service is isolated within the medical profession, and doctors in prisons sometimes bear the brunt of the hardening of attitudes which results from the criticism of prison officers and administrative staff. The recruitment of suitable Medical Officers remains inadequate and both full-time and part-time staff are about one-fifth below complement. Although some Medical Officers have a diploma in psychiatry, there is a tendency for promotion to be weighted in favour of administrative posts so that the best qualified Medical Officers are not engaged in clinical work. Unfortunately many of the Medical Officers with psychiatric qualifications are expected to retire in the next few years and it is very unlikely that they will be replaced by colleagues with similar experience.

The working environment for Medical Officers is poor both in terms of physical amenities and back-up services (e.g. secretarial), and their clinical practice is restricted largely to males of one socio-economic group. Medical Officers are unable to follow up their prisoner-patients into the community, or be involved in work with families or offenders who receive sentences other than with imprisonment. Ethical problems are raised by the demands of non-medical staff but the isolated Medical Officer tends to meet these by denying that there is conflict (169).

The Howard League for Penal Reform also raised significant questions about the Service at this time. The League argued that complete integration into the NHS was "an ideal to be aimed for":

Problems arise if an institution makes unreasonable demands that conflict with the doctor's duty to provide medical care, such as asking the doctor to certify his patient as fit to undergo cellular confinement. There is a strong ethical case for arguing that punishment is different from everyday matters like sickness certificates, and that prisoners, like other people, should have a doctor whose undivided commitment is to his patient. In prison practice such conflicts might be more readily exposed if the doctors involved were no longer prison service employees (170).

The issue of prison conditions and the impact on the health and safety of prisoners continued to be a dominant theme in the 1980s. The Chief Inspector of Prisons wrote in his first annual report about the "degrading and brutalising conditions" and the fact that key aspects of fire precautions "were often missing" in the prisons he visited (171). This omission was due to the fact that prisons fell under the category of Crown Immunity which meant that prison buildings were immune from fire and environmental health regulations. In other inspections the Chief Inspector found:

hygienic conditions in many jails are appalling. At Birmingham, for example, the food store was found to be dilapidated and dirty water ran down the walls and 'there were regular, infestations by vermin' (172).

In August 1985, the Home Secretary confirmed that prison dentists were to be asked to "limit the treatment of inmates and work within the financial constraints of the prison service". Prison dentists themselves complained they had been unable to complete treatment because the overcrowding in prisons meant:

large numbers of prisoners were regularly moved round the country at short notice. They have also protested about being asked to break their terms of contract with the National Health Service to provide treatment on grounds of need and not on grounds of cost. One Home Office remand centre near Wigan with 350 inmates has set a budget of £2,595 for dental treatment for the present financial year. The prison dentist estimates that it will be exhausted by October, after which time prisoners would have to be refused treatment (173).

The following year, the House of Commons Social Services Committee published its report on the Prison Medical Service. In May 1985



the Committee had decided to undertake an inquiry into the P.M.S. in the course of which members visited 19 prisons. Additionally, it received "much written evidence .... from people working in the Prison Medical Service and their organizations, from a wide variety of other bodies both medical organizations and bodies concerned with the welfare of prisoners, and from a large number of former prisoners" (174). The Committee pointed out its inquiry was not the first but that "various select committee reports have identified deficiencies in Prison Medical Services and made recommendations to improve them" (175). The Committee also indicated that its report should not be "construed as further criticism of prison doctors" but was written "in the spirit of planning health care for the future". Members were clear on where they stood on the issue of health care for the confined:

In view of some of the rumours we had heard, we were surprised at the generally good standard of care for physical ailments and the fact that access to treatment is often at least as readily available as for those outside prisons. We have taken as a starting point in our inquiry the principle that prisoners are entitled to the same standard of medical care as would be available to the community as a whole under the National Health Service. The PMS is at present understandably open to criticism that such standards are not maintained in prisons. Whether such criticisms are founded on fact or on rumour is not the point. The Government needs to be seen to be beyond reproach in its provision of medical care to prisoners (176).

This curious paragraph was then followed by a series of comments on the conditions inside and the impact that these conditions had on the treatment of the confined. The Committee argued that "prison inmates are being kept in conditions which would

not be tolerated for animals" (177). These remarks were directed at a number of practices inside including the unhygienic and degrading daily process of slopping out which because of the lack of fixed sanitation meant that in Norwich prison:

the prisoners queue up with their pots for the few toilets on the landing. The stench of urine and excrement pervades the prison. So awful is this procedure that many prisoners become constipated - others prefer to use their pants, hurling them and their contents out of the window when morning comes (178).

The Committee's views were supported by a Health and Safety Report for Bedford prison which was submitted to Members as part of a memorandum from the Royal College of General Practitioners. The report began by pointing out that life in a building which was over 100 years old and contained more than double its capacity could not "be in any way healthy or safe. The overriding health problem is overcrowding" (179). The report then detailed a grim series of often appalling conditions including the bathhouse where:

in one corner there was mould between the tiles and the tiles themselves were dirty. The fact that prisoners are only allowed one bath per week I suppose dates back to the time when people were sewn into their underclothes for the winter. It is dirty, unhealthy and unacceptable. Prisoners should have at least one bath every day (180).

The conditions in the hospital were also highlighted:

There has still been no action taken about moving the dental surgery to alternative accommodation. Various plans have been discussed but not come to

fruition. Thus the hospital continues to have extremely bad staff facilities. Despite having to deal with dirty infections, violently ill patients, staff have no changing or locker room and no staff shower. The association room for the inmates is totally inadequate. There is no drain outside the strip cell, into which dirty water can be washed when cleaning out this cell when it has been fouled. In consequence the foul water contaminates the main hospital corridor. The cell itself has chipped flaking paint making efficient cleaning of the walls impossible (181).

The Committee further argued that the lack of prison officers affected both *"health in prisons and the availability of medical treatment"*. Members heard from the Institution of Public Servants who stated:

If there are no prison officers available to bring an inmate from the cell to the doctor, the inmate does not see the doctor. If there are no prison officers available to escort the inmate to a hospital appointment, the inmate does not get to the hospital appointment (182).

Similarly, the number of prisoners coming through the system meant that medical examination for new inmates was *"often perfunctory to the point of uselessness"* (183). The Association of Members of Boards of Visitors told the Committee that at Wormwood Scrubs it was not unknown for upwards of 50 prisoners to be examined in the space of an hour. The Committee found that this was *"deplorable clinical practice and a waste of time"* (184). In its evidence the Prison Reform Trust pointed to an important implication for the P.M.S. with regard to the conditions:

.... our awareness of how institutions work suggests that it is likely that, for example, medical officers do not speak out loudly enough against living conditions in prison, which no one disputes are bad, sometimes appalling. It is inconceivable that an individual, however professionally dedicated, who works solely within and owes his loyalty and career prospects to, an enclosed organisation such as the Prison Service, could retain the independence of mind necessary to develop and express cogent and effective criticism of the same organisation (185).

Evidence from a range of groups including the Prison Reform Trust, the National Association for the Care and Resettlement of Offenders, the Howard League for Penal Reform, MIND, and the National Association for Probation Officers raised a number of serious questions about the role of the P.M.S. and the issue of integrating the service with the NHS. The Royal College of General Practitioners supported this and outlined what it termed as eleven "objectives for change". These included an end to overcrowding, the disassociation of prison doctors from supervising punishments, the urgent upgrading of the notes and records in the P.M.S. and the development of a directive role for the prison doctor concerning the environment of the prison "including the content of the diet, smoking in the prison, and the level of occupancy which is tolerable":

Prison doctors must recognize and treat serious disease and at all times maintain the priority of the needs of the patient over that of the establishment. This would be a reversal of the present instructions as spelled out by Mr C.J. Train at the 1985 Prison Medical Officers' Conference .... The whole work of the prison medical service should be audited. This should not be hidden behind the Official Secrets Act. The audit should preferably be done by groups of peers but it should be seen to be done and the results published. A comparison with medical care in the community would be easier if prison doctors were employed within the National Health Service .... The

whole morale of the prison medical service needs to change from defensive paranoia to aggressive investigation, standard setting and openness to outside scrutiny (186).

The Royal College of Psychiatrists was more circumspect in its recommendations but did argue that the P.M.S. should be managed by a single body which would be either a joint board of the DHSS and the Home Office or by the DHSS itself. Such a move would mean that "there would be less conflict of roles for prison doctors":

The Home Office should recognize that both administering a system of punishment and at the same time procuring the health of those being punished are incompatible objectives .. Historically, the prison medical officer's role has developed into that of a referee who could be relied on to support the home team. The prison doctor's role outside the provision of health care needs reviewing (187).

The Social Services Committee, for its part, made 58 recommendations which Members felt when taken together "can transform the Prison Medical Service into a prisoners' health service, less doctor-dominated, more professional, primarily concerned with the delivery of multi-disciplinary health care and in good working contact with the NHS, universities and the probation service" (188). The government's response to the report was published in March 1987 (189). In this, it set the Committee's recommendations within the more general context of the new prison building programme which had been announced in October 1983. This programme, it was argued, would ease prison overcrowding and increase the access that prisoners had to

sanitation facilities. The response conceded that "conditions in local prisons and remand centres are far from ideal particularly so for the purpose of conducting medical screening examinations" (190). The government maintained that the building and refurbishment programme would in time "provide some easement" but added ominously "the Department will continue to explore what further measures might be taken, though it must be realistic about the prevailing constraint on resources" (191). Such future projections were doing little to alleviate the difficulties prisoners were experiencing. In the spring of 1987 Chris Shaw highlighted once again, a range of areas affecting the health care of the confined. These included: the lack of opportunity for prisoners to take responsibility for their own health; prisoners who reported sick and stopped work losing a day's pay; medical records for prisoners serving less than two years not being requested by the P.M.S.; losing the medical records of long-term prisoners as they moved around the system; and the inability of prisoners to bring medicine prescribed by outside doctors into the prison. Finally, there was:

no confidentiality between doctor and prisoner, medical notes are part of the prison record and used in management and allocation decisions. A doctor can, at one and the same time, treat a prisoner for a medical condition, comment on his/her suitability for parole and sanction punishment. Prisoners therefore can have no confidence in the doctor's independence, for the prisoner's interests cannot be exclusive, or even paramount, in the doctor's decisions. Prisoners have no choice of doctor and cannot, in any circumstances, ask for a second opinion (192).

By February 1988, the increasing number of individuals being remanded in custody meant that there were no places available in the remand centres. Consequently, prisoners were being held in police cells. One prisoner who was regarded as mentally ill was being held in a police cell in Grimsby with two other men. The man's lawyers successfully applied to Mr Justice Simon Brown for leave to seek an order compelling the Home Secretary to arrange adequate medical and psychiatric supervision as well as suitable accommodation for him. The judge was troubled by the fact that "remand prisoners were not getting medical reports and the treatment they needed for their own and the public's safety" (193). Prisoners thought to be suffering from mental illness were also being moved between police stations with the result that doctors could not find them in order to assess the state of their mental health (194). In May 1988, the annual report from the Board of Visitors at Wandsworth prison was published. It described the level of sanitation in the prison as "disgusting, degrading and a public disgrace" (195). It also warned that the prison faced the possibility of a serious outbreak of infection and disease. Prisoners were being forced to wrap excrement in pieces of paper and throw the package from the cell windows. When cell buckets were emptied in the morning:

prisoners and officers frequently have to paddle through other men's urine towards the end of the slopping out session as the drains cannot cope with the volume of use .... men are issued with only one shaving bowl ... They not only wash their faces and shave in the bowls but they also wash their hands in them after using the slop buckets in their cells. If their hands have faecal matter on them, contamination of the bowl

would take place. As there is inadequate disinfectant this would present risks when eating utensils are washed in the bowls later (196).

The Board also made an interesting and important observation with regard to the Home Office's procrastination in alleviating the conditions. Members found it "depressing and exasperating" that recommendations for action by the Home Office in earlier reports "had not been implemented". It was:

incomprehensible that recommendations seeking fairness for prisoners and the barest minimum acceptable standard of washing and toilet facilities for prisoners and officers, are either seemingly ignored or result in promises of action which do not materialise (197).

At the same time, the Board of Visitors at Armley Prison, which was the most overcrowded in Britain, pointed out that staff shortages had led to a breakdown of suicide prevention measures. The number of prisoners had risen from 1,307 in 1987 to 1,380 in 1988. This was 111 per cent over the prison's theoretical maximum complement:

... the most serious shortfalls stemmed from shortages of medical staff, including intermittent closure of the gaol's hospital and failure to comply with the suicide instructions which require the interviewing of every new inmate to gauge the suicide risk (198).

In July, the question of suicide risk came into sharper focus, when the Chief Inspector of Prisons revealed that staff at Risley remand centre had ignored the mandatory instructions



governing potential suicide risks. Six suicides had occurred in the previous 12 months in conditions the Chief Inspector described as "barbarous and squalid" (199). Two of the prison's wings were:

filthy. Cells were small and dimly lit. Corridors were narrow. The low ceilings added to the oppressive atmosphere. Inmates spent the majority of the day in their cells ... A sense of squalor inside the wings could be gained by walking outside. We were told that the walls had been recently cleaned in order to remove deeply ingrained excrement and other foul matter which had for years been thrown out of cell windows by inmates. In an attempt to stop this practice metal mesh grilles had been placed over the windows. The response of those inside was frequently to smear these substances onto the grilles and to deposit other rubbish between the windows and the grilles .... The absence of integral sanitation throughout the prison is a major factor in the overall lack of human dignity (200).

When four prison officers were asked about a standard form relating to suicide risk the Inspector reported they "did not know what we were talking about" (201). The father of one of the dead prisoners said he would sue the Home Office for negligence. His son had been sent to the remand centre because magistrates thought it would be:

the best place for him because it had a hospital wing. We visited him two days after he was sent to Risley and we were very surprised to find that he was in a cell and not in the hospital. He was being treated as a normal inmate (202).

Finally, the Chief Inspector raised serious questions about the design of the prison which through its lack of integral sanitation "laid the foundation for hopelessness and apathy" (203).

The Home Secretary responded to the report by indicating that £50m was to be spent on re-developing the prison which would secure a better future for the prisoners. This was to be part of the new prison building programme for the 1990s. However, there were already serious questions being raised about the programme. In May 1988, the Board of Visitors at Full Sutton, which had opened in 1987 drew up a list of 18 design faults in the prison. The Board accused designers of wasting public money in following "an already discredited design" in the computerised alarm systems. The hospital wing was also criticised for lacking integral sanitation and dental cover or equipment (204).

Prison medical policy and practice was therefore caught up in the continuing debates about the adequacy of medical care for the confined. As this and the previous chapter has shown, this question has had a long and controversial history within penality. As I have also indicated, the issue of the conditions of care, discipline and regulation ran parallel with debates around the role of psychiatry and psychology within prisons and the relationship between the ideology and practice of these discourses and the normalisation of the confined. The issue was again to surface in the 1980s over the relationship between state psychiatry and black prisoners.

### Medicalising Black People.

An increasingly important dimension in the debates around British prisons in the 1980s has been the question of the incarceration

of black people and their subsequent experience behind the walls. That experience has been less well documented than the experience of black people in other parts of the criminal justice system, most notably their relationship with the police (205). Indeed, until 1986, it was difficult to obtain bare statistical information on the number of black people in the prison system. In that year, the Home Office released figures which indicated that about 6% of male and 12% of female prisoners were black while the same groups comprised of 1% and 2% of the population respectively (206). These figures, however, need further elaboration. As the GLC Ethnic Minorities Unit has pointed out, there is a concentration of black prisoners in the South-East of England and the population is largely young. That concentration in terms of geography and age means:

Ashford Remand Centre contains high numbers of Londoners and the Home Office acknowledges that it holds 50% Black youth - but the unofficial estimate is nearer 70%. In Wandsworth prison, it is estimated that there are 40% Black prisoners. It is difficult to give estimates for the remand population of the Scrubs but the trend continues. The lifers wing of Wormwood Scrubs is estimated to have 25-30% Afro-Caribbean lifers (207).

The Unit also pointed out that the lack of monitoring made it more difficult to obtain accurate figures for women and that the estimates varied greatly:

A psychiatrist put the figure at 44% but there have been reports of 60% of women being from ethnic minorities. This would also include women who are being detained under the immigration laws prior to deportation - of whom there are an average 8-9% at any one time (208).

More recent figures, gathered by the National Association for the Care and Resettlement of Offenders (NACRO) indicated that 14% of prisoners in England and Wales came from what the Association described as the "ethnic minorities". This was more than twice the percentage in the general population. Differentiated by gender, NACRO's figures showed that on 30th June 1987, 13.6% of the male prison population were from the 'ethnic minorities' while the corresponding figure for women was 22.7% (209). The study indicated that sentenced black prisoners had fewer previous convictions than white people convicted of the same kind of offence. They were also less likely to be granted bail. The director of NACRO commented:

Taken overall, the evidence strongly indicates that black people are unfairly treated by our criminal justice system. The figures do not show that they are more prone to crime than white people but they do suggest that black people who offend are more likely to go to prison (210).

Within this general context, the relationship between black people and medicine has been a contentious one. In particular, it has centred on the question of mental health and Afro-Caribbean prisoners. From the mid 1960s, a number of cases emerged which illustrated the interrelationship between the penal system and the psychiatric network and how the powers given to criminal justice personnel under the 1959 and 1983 Mental Health Acts were being used:

the rationale governing usage of this cluster of powers is almost always framed in terms of 'protecting public interests' and is dependent on assessments of the person's 'dangerousness' - a

term so general and inclusive as to offer law-and-order agencies a wide scope for acting preemptively against what they consider to be potential disruption (211).

According to the Black Health Workers and Patients Group when non-medical or biological concepts such as "personality", "normal thought" and "appropriate conduct" are involved in the assessment of individuals psychiatry "is 'influenced by prevailing social categories and expectations, by the whole gamut of discourse and institutions concerned with policing and checking abnormality'" (212).

During the 1980s there were a number of cases involving black prisoners which raised issues around the psychiatric assessment of these prisoners, the medical treatment they received, the question of force-feeding, the use of drugs as controlling mechanisms and their certification as either mentally ill or insane which meant that they could then be transferred to state mental hospitals.

A number of recent studies provide support for the prisoner's contention that psychiatry and psychology as disciplines are working within a set of parameters which generate stereotypes about ethnic cultures and black people. As the Black Health Workers and Patients Group pointed out, the nature of psychiatry itself has to be questioned in this process:

does it have a methodology or merely an arbitrary conglomeration of rules and techniques dating back to its origins in an earlier period of crisis when the workhouses disintegrated and their populations

were redistributed in prisons, asylums, voluntary schools etc; does it have a theory or does psychology provide it with a series of psuedo-scientific hypotheses which are both anti-working class and racist; is it as it claims to be, a scientific area of study or a twilight zone where pseudo-science begins to shade into myth? (213).

In November 1987 a three year study by MIND indicated that the additional powers granted to the police under Section 136 of the 1983 Mental Health Act were being used "more against members of the black community than white in proportion to the population of ethnic groups." Additionally, the number of police referrals to mental institutions was far greater than was officially recognized by government statistics and that the police abused areas of the Mental Health Act (214). This conclusion was supported by another study by Roland Littlewood, a consultant psychiatrist at Middlesex Hospital which showed that black people were over-represented in regional secure units and high-security units such as Broadmoor. Littlewood's study itself paralleled a West Midlands research project which indicated that Afro-Caribbean blacks were 25 times more likely than white people to be placed under psychiatric care by the courts (215). Littlewood had also conducted a survey some years earlier. He found that black people were given heavier dosages of drugs than their white counterparts. He concluded that not only was there a tendency to view acute stress reactions in black people as symptoms of schizophrenia but that there were real problems of mental illness in the black community:

It's not just a question of poverty, it is a question of racism. A large proportion of people

in any society are vulnerable to mental illness but many of them live with stresses without becoming ill. My strong feeling is that black people are being driven psychotic by our society, that racism is indeed causing these high rates of mental illness (216).

McGovern and Cope also found that males of West Indian origin were "significantly over-represented" in the psychiatric hospital they studied. This was particularly true for compulsory detainees in the category of offender patient. They cited a number of reasons why this might be so. They did not offer firm conclusions but argued that more research and further study was needed (217).

Whatever the conclusion of academic studies, accounts by black prisoners of their experience continually reinforce and underline the pressure imposed upon them within the prisons. Describing her experience of 20 months in custody, one ex-prisoner indicated that:

about two-thirds of the Black women prisoners are drugged. In prison there's a system and if you don't play it they beat you up and attack you. And if you're black you get more pressure because you're not only fighting for prisoners' rights, you're fighting for your Black rights. The treatment of prisoners is so bad. I think on the whole the way women prisoners are treated is a reflection of society. Most of the drugging is to do with that. People are going around like zombies. You get institutionalised so that when women come out they crack up and commit more crimes (218).

These controversies have, as I have indicated, a long history and have been an identifiable element in medical practice within institutions since the late eighteenth century. The most recent demands for change provide a focus for raising more fundamental

questions concerning the reasons and rationale behind the reform of prisons in the late 1980s. As I indicated above, the government's response to the report by the Social Service's Committee was to point to the prison building and refurbishment programme that had been underway since October 1983. Officially this programme was designed to deal with overcrowding, improve conditions and, by extension, alleviate the unhealthy environment within which many prisoners existed. It was also designed to confine the increasing numbers of individuals whom the courts were incarcerating. By 1988, the prison population was hovering around the 50,000 mark. The UK had a larger number of prisoners per 100,000 of the population than almost any other Western European country. The government's building programme was costing £1 billion which was "more expensive in relation to gross domestic product than any other developed country" (219). By the end of the century, the prison system would have the capacity to hold 80,000 prisoners.

A critical reading of these expansionist reforms requires moving beyond the narrow view that they are concerned with alleviating appalling conditions or even dealing with the crime rate. Sociologically there is little evidence that this has ever been or indeed will be the case (220). Rather, when more prisons are built more individuals are likely to be incarcerated. The penal estate grows while conditions for many remain primitive. Within the UK the work of Steven Box and Chris Hale has been important in illustrating how the expansion of the prison system has been tied to the maintenance of order through disciplining surplus populations rather than with any simple desire to improve



conditions or fight crime (221). As they argue, the increased use of the penal sanction between 1971 and 1981 is related to:

the growth of unemployment which is itself a reflection of deepening economic crises, is accompanied by an increase in the range and severity of state coercion, including the rate and length of imprisonment. This increased use of imprisonment is not a direct response to any rise in crime but is an ideologically motivated response to the perceived threat of crime posed by the swelling population of economically marginalised persons (222).

As prisoners have become younger and blacker so sentencing policies and law and order campaigns:

are not that concerned to control serious crime. Rather they are more concerned to instil discipline, directly and indirectly, on those people who are no longer controlled by the soft-discipline machine of work and who might become growingly resentful that they are being made to pay the price of economic recession (223).

Building on this analysis, I have written elsewhere (224) about the expansion of the prison system as part of the emergence of what has been called the strong or authoritarian state. The work of Nicos Poulantzas, Stuart Hall, Paddy Hillyard and the Centre for Contemporary Cultural Studies (225) has been important in tracing the emergence of this state form and the desire to establish a much more integrated and less informal process of justice in the United Kingdom (226). In this context then, the prisons can be seen to be concerned both with individual regulation and with the policing of wider social divisions. Discipline, individualisation and normalisation are cornerstones of these institutions within which the emphasis on

security, order and control invariably vanquish any notions of rehabilitation and reform.

The prisons in the late twentieth century are themselves in a sense prisoners of a past and of a history in which discipline and the protection of the wider social relations of private property provided the mainspring for social policy and action. This is not to impose a deterministic reductionism onto social formations nor to adopt a fatalistic, non-contradictory analysis of how institutions work. Rather it is to point to the often overwhelming sense of discipline and regulation, which is deeply embedded in the programmes and policies of penal institutions and engraved in the consciousness of those who staff them. As these last two chapters have shown the present position on reform of the P.M.S. cannot be divorced from its history. Indeed, as Michael Ignatieff reminds us a historical perspective is crucial in helping to:

pierce through the rhetoric that ceaselessly presents the further consolidation of carceral power as a "reform". As much as anything else, it is this suffocating vision of the past that legitimizes the abuses of the present and seeks to adjust us to the cruelties of the future (227).

Medical and psychiatric discourses within penal institutions are a good example of Ignatieff's point. Through articulating ideas of benevolent care and the ceaseless but ultimately doomed search for individually located causes of crime, medical professionals have consolidated their position within prisons and the criminal justice process. However, as both this and the previous chapter have shown, a critical reading of the history

of medicine reveals the strong dialectical relationship between prison medicine and wider social processes. It has been this relationship built around the iron therapy of discipline, regulation and normalisation which has been the propelling force in its development. The next chapter which analyses the question of women, confinement and medicine illustrates still further these disciplinary processes.

Chapter 6

At the Centre of the Professional Gaze :

Women, Medicine and Confinement.

A popular saying in Alderson went as follows:  
They work us like a horse, feed us like a bird,  
treat us like a child, dress us like a man -  
and then expect us to act like a lady (1).

Like its original forbear of a century ago, the Prison Medical Service of the present day is generally a rather constrained and subservient creature. Yet the modesty of its current status represents a reversal of its fortunes. For there was a brief epoch in its history when even an equal partnership with the penal authorities would not have satisfied its ambitions: for a brief moment psychiatry actually sought to supplant penality. Ultimately this strategy failed, but as with other developments in the field, its localized achievements were never completely superseded or dismantled, but have left their legacy in the general medley of available options and provisions. This legacy is particularly important both in the women's prisons and in the provisions for psychiatric treatment on probation (2).

So far in this thesis, I have outlined a number of themes regarding the role of medicine in prison. The development and consolidation of medical power has been analysed from the last decades of the eighteenth century to the last decades of the twentieth. The analysis has been situated within the theoretical context of a critical reading of the work of Michel Foucault and his pioneering studies of power in prisons and asylums. However, as I pointed out in both Chapters 3 and 4, Foucault's work, while central to the analysis of power networks in these institutions, fails to consider gender differences in professional discourses. As Elaine Showalter has argued in relation to his study of madness and confinement:

Although anyone who writes about the history of madness must owe an intellectual debt to Foucault, his critique of institutional power in Madness and Civilisation ..... does not take account of sexual difference. While he brilliantly exposed the re-

pressive ideologies that lay behind the reform of the asylum, Foucault did not explore the possibility that the irrationality and difference the asylum silenced and confined is also the feminine (3).

In this chapter, I wish to build on Showalter's critique and in particular trace the historical shifts in, and contemporary debates around, the close relationship between medical professionals and women prisoners. While it has become a sociological truism that the lives and experiences of women have been neglected (4) it is untrue to conclude from this that women have been completely marginalised from medical and social scientific discourse. Indeed, as I shall illustrate, the reverse is the case. Criminal women, have been a central concern for prison managers and medical and psychiatric professionals within the penal system. They have been studied, probed and tested not only because of their supposed uniqueness but also because of the threat that they posed to the social order of the stable family relationship. This order was threatened by the existence of a criminal class of women. In that sense, regulation, discipline and normalisation were again key weapons in the struggle with this class. However, it was a regulation, discipline and process of normalisation quite different and distinct from that which those confined in the male prisons were to experience. And at the centre of this iron therapy stood the figure of the medical man.

There is a further dimension to this process which is also important to note. While medical and psychiatric professionals were, and are, central to the lives of women prisoners, they themselves can be understood as part of a wider professional

network whose concern with returning criminal women to their 'normal' role legitimated a level of intervention and surveillance which was much more intensive than that experienced by criminal men. From their initial contact with the criminal justice system through to their imprisonment and onto their release, such women have been confronted by a series of interlocking rules and regulations, programmes and practices administered by a range of groups and individuals and targetted to controlling, constraining and re-moulding their behaviour. More particularly, it has been the personal and moral life of the women which has stood at the centre of the professional's gaze, the target for what Peter Miller and Nikolas Rose have called "the development of precise techniques for the government of the self in the minutiae of its existence and experience" (5). In that sense, liberal notions of rehabilitation and reform have masked a deeper, more fundamental strategy namely to reshape the very spirit of the criminal woman back to the role for which she was seen to be biologically and sociologically suited - that of wife and mother. In short, it was a strategy to remould the subjectivity and the consciousness of the confined to forge links "between the subjective capacities of the individual and the well-being of the nation" (6). Taking this position does not mean engaging in either conspiracy theory (7) or as Hilary Allen points out, positing an analysis which subsumes all gender relationships under:

patriarchy as an all-embracing, all-powerful system of male dictatorship, which determines more or less violently, all the forms and outcomes of social relations, including those of psychiatry and law (8).

Allen argues that such a perspective disallows the exploitation

of contradiction and intervention through political action so that while:

The world is full of sexism ... this sexism does not operate uniformly nor inexorably nor by any superhuman machinery. Other principles sometimes subvert it (principles of order and control, for example, which coerce men no less than women) and at times it subverts itself (as when sexist assumptions of women's frailty, which elsewhere operate to women's detriment, are tactically employed to their advantage) (9).

Allen's study of the relationship between gender, psychiatry and judicial decisions presents an alternative analysis. Using Foucault's notion of discourse and applying the concept to medicine and the law, she seeks to move beyond the language and documents of medicine to a position which emphasises discourses as:

Structures of knowledge, through which members of these (medical and legal) professions understand and decide things. They are structures of social relationship which establish different obligations and authorities for different categories of person, such as patients, offenders, doctors, judges, probation officers and so on. They are impersonal forms, existing independently of any of these persons 'as individuals'. They are historical and political frameworks of social organization, that make some social actions possible whilst precluding others. .... It is an analysis that belongs to the concrete world of serious everyday decisions (10).

Once again, therefore, this chapter will build on this critical reading of Foucault's work to analyse the relationship between women, medicine and confinement. This critical reading allows for the utilisation of key Foucauldian concepts such as power, knowledge, surveillance and normalisation in the creation of



the female subject within prisons and other institutions.

At the same time, as Allen recognizes, and as I shall illustrate, medical power was challenged from within and without the walls, there were contradictions in, and conflicts over, penal strategies for women offenders. Policies were introduced and quickly evaporated and there were theoretical, practical and political limitations on the impact of medicine in the lives of confined women. As Allen concludes:

... discourses are not simply mystifying or irrelevant surfaces of words. On the contrary, they are ways of understanding, deciding and doing things, they are themselves the machinery of power in which both professionals and their subjects are equally enmeshed ... it is the offenders who are most obviously coerced by the power of these discourses: it is on the course of their lives that these medico-legal pronouncements have the most poignant or violent impact. Yet the pronouncements of professional personnel are also constrained by the same power. Doctors and sentencers cannot just make any decision; they cannot even make what they perceive to be the best decision. They too are constrained in their social actions by the discourses they speak but cannot own (11).

There is a final dimension to this analysis which I have also pointed to in Chapters 3, 4 and 5. Foucault's work allows us to see the dynamics of power in micro situations, an ascending analysis which reveals "the particular histories, techniques and tactics of power" (12). He wishes to develop an understanding of power in which "attention has to be given to the mechanisms, techniques and procedures of power, literally to how power functions, only then will it be possible to see how at a precise conjunctural moment particular mechanisms of power became economically advantageous and politically useful" (13). At the same time as these chapters indicated, such micro techniques

of power were increasingly bound up with the developing English state. Rachel Harrison and Frank Mort have attempted to deal with both aspects of this question by indicating the usefulness of Foucault's analysis of discipline and regulation in relation to sexuality in the nineteenth century. In their view "his model marks an advance over simplistic notions of 'social control'". At the same time, the regulation of sexuality via the internal specificities of particular discourses takes place in the context of:

wider sets of relations which also structure sexual and moral practices in the nineteenth century. Our own investigation has attempted to hold to a two fold formulation in analysing particular items of legislation governing sexuality and the sexual division of property: both to the internal history of legal structures, as that history is not synchronic with the development of capitalist economic relations, and to an awareness of the particular economic, political and ideological shifts in the history of capitalist organization in the nineteenth century (14).

Harrison and Mort's framework and Mort's subsequent work allows space for an analysis which attempts to deal with both micro and macro levels of power without reducing social theory either to a level of superficial interactionism or crude reductionism. More specifically, Pat Carlen and Anne Worrall have attempted a similar theoretical synthesis in relation to women's deviance and the state. First the construction and experience of femininity at a subjective level is important:

Femininity is routinely constituted within a number of discourses which circumscribe not only a woman's behaviour but also the image which she has of herself and her relationships with other people. Women's experiences of 'being female' are mediated by their bodies, their minds and their social interaction. The discourses within which these experiences are

structured are constituted by sets of relationships which cluster around notions of domesticity, sexuality and pathology. These discourses themselves inter-relate and are not mutually exclusive. As with the image of a kaleidoscope, each discourse organises its components uniquely but not arbitrarily. A discourse may contain paradoxes and discontinuities, but in its realisation these are transformed into unity, coherence and hierarchy (15).

Second, this construction through discourses, is also influenced by professional groups and the state itself intervening into family life. In this context:

..... the family is seen as an agency of 'supervised reproduction', supported by means of 'contract and tutelage' ..... The means for achieving this objective varies with the class of family, but the key site of intervention is always the woman as mother. The offer to the middle-class family is that of a contract, an alliance between the family welfare professionals (doctors, psychiatrists and social-workers) and the mother. By promoting the mother as educator and medical auxiliary, the state secures its influence over the family, and the mother increases her power within the domestic sphere. But for 'unstructured', 'rejecting' or 'deficient' families the objective must be achieved by a different means. It is then the mother herself who requires education and supervision - not directly, but through the medium of social work and child psychiatry, with their emphases on the needs of her children. In this way 'the prophylactic cravings of psychiatrists and the disciplinary requirements of the social apparatuses' converge ..... The discourse of domesticity is legitimised by privileged (predominantly male) professionals who are empowered to circumscribe the behaviour of women through alliance or tutelage. Their power is frequently delegated to (predominantly female) semi-professionals (e.g. nurses and social-workers), who mediate between them and the women who enter the roles of patient or client. These are the 'wise women' ..... who, in addition to translating 'expert knowledge' into 'common sense' for the consumption of the always-already failing woman, also purvey an authoritative role model of normal womanhood (16).

The historical and contemporary experiences of women in prison

provide a good example of this theoretical position.

### Women and Medicine in Historical Context.

In Chapter 4 I questioned the conventional account of the history of criminology which put the Italian positivist Cesare Lombroso at the centre-stage of the discipline's development. As I indicated, Lombroso's theories built around Criminal Man, published in 1876, were greeted with scepticism by the British medical establishment. Whilst acknowledging that his biological explanations of criminality could have some relevance, the men who populated the profession of medicine recognised that such reductionist views constrained their power to intervene and influence both individual treatment and wider social policy. Conventional accounts have missed this important theoretical and political point. There is a second dimension which has also been missed which relates to the question of gender. Traditional accounts of the history of women's criminality begin with Lombroso and Ferrero's book The Female Offender, published in 1895. However, as Susan Edwards points out, a closer and more critical reading of this history and social policy interventions uncovers an alternative account. For criminal women and prisoners, it was the medical profession who set the parameters for, debates around, and responses to their deviance:

The real and pragmatic influences on the criminal law and the administration of justice during the nineteenth century were in fact medical and gynaecological theories on women and crime. They too

were based on the tenets of biological positivism but were exerting an influence in the courts well before the advent of Lombroso's work on the female offender and, indeed long after. From the beginning of the nineteenth century, medical practitioners, mental health physicians and gynaecologists conceded rather more specifically that criminality in women could be explained by the physiological episodes to which they were subject. Thus menstruation, pregnancy, lactation and the climacteric were regarded as 'crisis periods' when women might behave erratically or criminally (17).

In that sense, then, we see the intervention of medical professionals into women's lives at a much earlier historical moment than has hitherto been recognized. This professional concern, and the biological explanations that flowed from it, overlapped with and indeed underpinned, the emergence of a new set of institutions and practices designed to deal with deviant women who were classified into different social groups: the prostitute, the criminal, the lunatic and the undeserving poor. This classification was itself underpinned by a system of disciplined morality, women in whatever moral group they inhabited were subjected to the surveillance and gaze of medical professionals and concerned reformers eager to rescue them from their debauchery and deviance. This inter-relationship was, as I shall indicate, to continue into the twentieth century.

In October 1811, Hester Harding was arrested for want of sureties. As she was ill she was sent to the infirmary in Gloucester prison. When she recovered she appeared to the prison doctor to be affecting insanity. To deal with this she was given a cold bath with "a little hot water added as it was December" (18). When this method failed, a strait-jacket was tried and according

to the prison authorities, this proved successful. When Martha Jeynes was also suspected of feigning insanity:

an electric shock was tried instead, which the surgeon noted 'I am pleased to say produced an immediate desired effect, she fell to her knees, confessed and promised to conduct herself properly in the future'. The 'Electric Machine' was used again when she became obstinate but without effect so the surgeon directed the Turnkey to drench her with Beer Caudle and this proved effective. She was serving two months for stealing butter (19).

These two incidents from the early nineteenth century crystalise a number of issues that were to continue into the twentieth century. First, the role of doctors in managing women in institutions. Second, the relationship between women, madness and psychiatric intervention which became a dominant issue in the nineteenth century particularly by the 1850s when women formed the majority of the population in asylums (20). Third, the question of the resistance of women to psychiatric and medical power into their lives. Fourth, the emergence and consolidation of professional (overwhelmingly male) groups allied to other class fractions for the regulation and surveillance of the body and mind of confined women. Finally, the inter-relationship between different institutions, the prison, workhouse and asylum, and the movement of women between them. This occurred within an over-arching framework where "humanitarianism was inextricably linked to the practice of domination" (21).

Elizabeth Fry's interventions into the prisons in December 1816 are a good early example of the above points. As Michael Ignatieff

indicates, women prisoners in Newgate were classified and separated, their appearance changed, their hair cut and regular work patterns were introduced particularly sewing.

Altogether:

in place of the idleness, fighting, and swearing she had substituted quiet industry and prayerfulness. As her brother-in-law, Thomas Fowell Buxton put it she had turned a "Hell on Earth" into a "well-regulated Manufactory" (22).

Fry established a committee of eleven Quakers, plus the local clergyman's wife and formed The Association for the Improvement of the Female Prisoners in Newgate. She informed the Alderman of the City of London that "women should have no male attendants other than medical men or ministers of religion" (23). In 1827 she published Observations on the Visiting, Superintendence and Government of Female Prisoners. According to June Rose the booklet advocated a change in the status of women in terms of urging that there should be opportunities for them outside the home. At the same time, this suggestion was set in the context of the duties of women in the hierarchy of society:

I wish to make a few remarks ... respecting my own sex, and the place which I believe it to be their duty and privilege to fill in the scale of society ... Far be it for me to attempt to forsake their right province. My only desire is that they should fill that province well; and although their calling in many respects, materially differs from that of the other sex and is not so exalted a one yet ..... if adequately fulfilled, it has nearly, if not quite, an equal influence on society ..... No person will deny the importance attached to the character and conduct of a woman in all her domestic and social relations, when she is filling the station of a daughter, a sister, a wife, a mother or a mistress of a family. But it is a dangerous error to suppose that the duties of females end here .... no persons

appear to me to possess so strong a claim on their compassion ... as the helpless, the ignorant, the afflicted or the depraved of their own sex ..... During the last ten years much attention has been successfully bestowed by *women* on the female inmates of our prisons ... But a similar care is evidently needed for our hospitals, our lunatic asylums and our workhouses ... Were ladies to make a practice of regularly visiting them, a most important check would be obtained on a variety of abuses, which are far too apt to creep into the management of these establishments ... (24).

The development of prison (and asylum) regimes based on domestic routine and paternalistic surveillance was not accepted easily by the confined women. In 1817, women in Millbank engaged in a number of protests concerning food and the "overzealous punishment of two prisoners" (25). These protests were followed by a general disturbance which was broken up the following day through the intervention of the male-dominated Bow Street Runners:

The 'ringleaders' of this uprising were punished, but it did not stop the general protest and resistances of the women. In 1823 another general disturbance broke out, accompanied by attacks on wardswomen and the matron. According to the governor's report, this uprising included a plan to murder the matron, one female officer and the chaplain (26).

The male commentators of the time couched the explanations of such behaviour in explicitly moral terms. In September 1850, when workhouses committed refractory paupers to Coldbath Fields prison, George Chesterton remarked that "the inconceivable wickedness of those girls was absolutely appalling. Their language, their violence and their indecency shocked every beholder" (27). In 1855, the Directors of Convict Prisons talked in their annual report about "the problems of 'reckless'



women and their 'violence and passion'" (28). When transportation was replaced by penal servitude there were a number of collective protests between 1853 and 1859 when clothes were destroyed, bedding torn and windows smashed. Religious sermons were rejected, the silent system was subverted by the use of the knocking alphabet and the women continually struggled to find new methods of undermining the spartan uniforms and lack of make-up which the authorities attempted to enforce. This included scraping the walls and using the powder from the whitewash to whiten their complexion (29). Singing loudly, shouting, noise-making and smashing the cells were also common forms of protests. Finally, there was self-mutilation and suicide as the final response to the pressure of the penal regime:

Penal authorities sometimes demonstrated considerable insensitivity to this behaviour, describing such women as 'troublesome prisoners' who were merely attempting to gain entry into the infirmary where they might converse with other women and receive an improved diet. One woman who covered her body with her own excreta for six months was described by the Brixton medical officer as engaging in 'deceitful behaviour'. He was referring to what he judged as her attempts to feign madness, and it seems not to have occurred to him that her persistent behaviour could have anything to do with the nature of her confinement (30).

The mid-Victorian predilection for institutionalising deviant women was thus marked by stiff resistance to the regime and to its managers. This occurred across institutions. As Judith Walkowitz has pointed out, the Contagious Diseases Act of 1864, 1866 and 1869, allowed for the confinement and isolation of women and the medical policing of their behaviour. The disciplined programme of the Royal Albert and Royal Portsmouth Hos-

pitals followed a similar regime to the women's prisons:

The women could only be transformed if order was put into their lives and a strict regime enforced. Accordingly the inmates were subjected to work and time discipline; their daily lives were punctuated by work, prayers, mealtimes, lessons in ablution and reading classes (31).

They had been in the words of one contemporary "desexed" and therefore the domestic and hygienic thrust of the regime, led by the nurses and the matron was designed "to inculcate the women in moral and social values" (32). The regime was also designed to train the women in:

deference and subordination. The social world of the hospital reproduced the patriarchal and class order of Victorian society. The male doctor was to reign supreme as the chief disciplinary and medical officer. The matron usually a middle-aged spinster or widow would act as his subordinate and female role model to the inmates (33).

Here too, resistance was a central part of everyday life. At the Royal Portsmouth hospital there were frequent disturbances in the ten years between 1873 and 1883. For those who resisted dark cells and solitary confinement were used. In the "soup riot" of January 1873, which lasted for two days, seven women were arrested and eight placed in the confinement cells. After five days, a police inspector was called in to investigate and to question those involved:

After further questioning, the meaning of the "soup riot" became clear. The resident medical officer had been "too readily disposed to adopt coercive measures in the repression of any acts of insubordination." Because he felt some of the women had been "saucy" with him, the doctor had

refused to examine them the next week. Angry and disappointed, the women lashed out at the conditions most immediately intolerable: watery soup, restricted access to their mail, and generally harsh treatment. Fundamental, though, was a simple desire to get out. As Sloggett wrote later, "I have found that many are discontented at what they think is often unnecessary detention after they are fit to be discharged. I have to believe that most of the riots in the Hospital originate in a wish to go out on the part of some one or other of the ringleaders." It was no coincidence that the day after Sloggett's arrival Laura Lewis was declared cured and discharged (34).

In the 1860s women at Bethlem and Colney Hatch asylums were also regarded as noisy, troublesome and abusive. As Elaine Showalter indicates:

since women were accustomed to being ordered to submit to the authority of their fathers, brothers and husbands, doctors anticipated few problems in managing female lunatics. Yet rebellion was in fact frequent. Victorian madwomen were not easily silenced and one often has the impression that their talkativeness, violation of conventions of feminine speech, and insistence on self-expression was the kind of behaviour that had led to their being labeled "mad" to begin with (35).

Such behaviour could however have serious repercussions. In Bethlem, solitary confinement was used while at Colney Hatch "they were sedated, given cold baths, and secluded in padded cells, up to five times as frequently as male patients" (36).

For the managers of prisons, asylums and workhouses the cause of ill-discipline was seen to lie in the peculiar temperament and biology of women criminals. This allowed them to call for medical and psychiatric intervention. Arthur Griffiths, a prison governor, pointed to his own experience with women prisoners:

I forbear to enter into any psychological enquiry into the causes or reasons, but will merely state the facts drawn from my own experience, that the female "side" of a prison gives more trouble to the authorities than the male. It has been officially recognized nowadays that the most effective government is that exercised by a doctor; so many questions of hyper-emotional temperament, of hysteria, of peculiar physical conditions arise, that the chief official in every large prison today is invariably a medical man (37).

Griffiths provides an excellent insight into the life of a state servant through his autobiography which was published in the early part of the twentieth century. In the book he discussed the history of women prisoners at Millbank and argued that "the intractability of the female candidates for reformation was painfully shown from the earliest days of the penitentiary". The first group of women received in the prison:

were found to be suffering from fits, imaginary as it proved. The affliction promptly disappeared when the Governor stated that the best treatment was to shave and blister the heads of all who were attacked. But a number who refused positively to have their hair cut were removed to the hulks. The female prisoners were fanciful about their food, refused to eat brown bread, and raised an uproar in chapel, chanting "Give us our daily bread." The slackness of supervision resulted in the most reprehensible form of correspondence and intrigue between the males and the females, and at that period, it must be remembered female officers had been but little employed; the first matron at Millbank was the first who had ever been appointed to such a post. The poor creature little knew the task she had undertaken, and was soon terrorised by her reckless charges, who repeatedly assaulted and maltreated her, and on one occasion she narrowly escaped with her life, only saved thanks to the timely rescue of a wardswoman, or well-conducted female prisoner. Violent outbreaks were of continual occurrence in the female pentagon, and once a conspiracy was discovered, carried on by the circulation of a mysterious bag, which was thrown down in the exercising yard, to be picked up and passed on from hand to hand, so that its seditious contents might be read, and the plot extended. Its avowed aim was to murder the chaplain, the matron, and a well-

hated female officer; but, as usual, the secret was betrayed, for, as I have had occasion to remark before, there is no fidelity to each other among prisoners, and mutinous combinations never succeed (38).

The chaplain was a particular target for the women:

No respect was shown by the women for sacred things, or the sacred office of the chaplain. One of them one day jumped up in the middle of divine service and cried, "Mr. Russell, Mr. Russell, as this is the last time I shall be at chapel, allow me to return thanks for favours received." On another occasion screams and huzzahs were heard among the female congregation, and a number of prayer books were thrown at the chaplain's head. When he had finished his sermon with the accustomed "Let us pray," a voice was heard crying, "No, no, we have had praying enough." The condition of the females was at its worst during the Chaplain-Governor's reign. He constantly deplores in his journals "the behaviour of the female pentagon is frightfully disorderly." "Bickering, bad feeling, disputes are increasing." "Great laxity prevails, no discipline, no attempt to enforce non-intercourse ...although to the ladies who visit them (disciples of the estimable Mrs. Fry) the females quote Scripture and speak piously ..... their minds remain in a state at once the most depraved and hypocritical" (39).

He discussed the problem of breaking out which was the tendency of the prisoners to demolish cell furniture, smash windows, destroy clothing, barricade cell doors and use "strident and offensive language" (40). There were also fights between the prisoners and assaults on prison staff.

The conflict between the prison and one prisoner continued for a year. Julia St. Clair Newman confronted the prison authorities at every turn including throwing a can of gruel over the governor. While there were doubts concerning her sanity, she was nonetheless removed to the dark cell where she sang songs, blackened

her eyes, beat herself on the cell floor and attempted suicide:

To curb her violence the surgeon devised a special strait-waistcoat, but she was no sooner placed in it than she released herself and tore it to ribbons. No means of restraint would hold her. A strong strait-waistcoat was slashed to ribbons, and it was found she had secreted a pair of scissors under her arm. Not strangely, she was a terror to the whole place (41).

The governor unable to control her argued that she should be removed from prison, in order to preserve the discipline of the institution:

He begged that she might be sent elsewhere, pleading that "all prisoners whose insubordinate spirit does not yield to the ordinary method of treatment should be removed ... the moral injury they do to the residue by long-continued examples of rebellion is incalculable" (42).

She was transferred to an asylum whose authorities decided she was not insane and so transferred her back to Millbank. Here the pattern was repeated:

It was the same old story, the same acts of insubordination again aggravated by feigned suicides, and successful combat with every fresh attempt at restraint. Again and again she conquered. Handcuffs, an especially small pair for her slender wrists, were useless, so was pinioning her arm with strong tape; she was tied to a bedstead with strong webbing, but got out of it. The surgical instrument makers invented a new kind of waist-belt combined with handcuffs, but all to no purpose. At last she was fastened to the wall by a chain passed through a ring and padlocked. "This security was of short duration; before morning she had slipped through the chain. It was again placed upon her in a more effectual manner, under instead of outside ... As she had destroyed so much of her bedding, I ordered her to have no more bedclothes ... when she heard this she frightened the female officers with the frightful and horrible imprecations she uttered." Lastly

a pair of leather sleeves were constructed of extra strength, which came up to her shoulders and were strapped across, also strapped round her waist and again below, fastening her hands to her sides, yet in the night she extricated herself from this apparatus, and it was found she had cut it to pieces with a bit of glass. Soon after this the order came for Miss Newman's embarkation, and she was sent across the sea to Van Diemen's Land, where the curtain fell upon her (43).

Griffith's view of women prisoners was based on a particular view of their nature:

Wise men will freely admit that the management of the softer sex by the stronger presents peculiar, it may be insuperable difficulties, but these are enormously accentuated when the moral sense has been weakened and the women have lapsed into evil ways (44).

He pointed to the "spirit of imitateness" which "is strong in women" and using a medical metaphor discussed how "quickly the contagion of misconduct spreads". This "imitateness" developed into more collective forms of protest in a northern prison where the population was "a rough, headstrong lot, very difficult to manage ..." When 12 of their number took to the roof, Griffiths left them for the night:

Meanwhile, I sent to a friendly magistrate hard by, begging him to meet me at the prison next day early, for I wished to have recourse to his powers of punishment, having none myself. I made other preparations to deal with my mutineers, and, passing on to an adjacent town, saw the Governor of the prison there, requisitioned from him all his "figure-of-eight" handcuffs, and carried them back with me next morning in a bag. The situation remained unchanged; the women were still under the roof, but no longer had access to the slates, for by means of a ladder the skylights had been reached and secured from the outside. Then the male officers went upstairs,

and, after a sharp scuffle, extracted the women from the alley under the roof, and brought them one by one to their cells. No sooner were they incarcerated than we, the magistrate and I, visited them, and he ordered each woman to be handcuffed, as the law permits when fears are entertained that she will do herself or another a mischief. There was never another outbreak among the female prisoners there (45).

In his earlier book Memorials of Millbank, which was published in 1884, he devoted a chapter to women and included a discussion of their insubordination. He felt that:

a really bad woman can never be tamed, though she may in time wear herself out by her violence. We shall see more than one instance of the seemingly indomitable obstinacy and perversity of the female character, when all barriers are down and only vileness and depravity remains (46).

And again he talked of how:

It is a well-established fact in prison logistics that the women are far worse than the men. When given to misconduct they are far more persistent in their evil ways, more outrageously violent, less amenable to reason or reproof. For this there is more than one explanation. No doubt when a woman is really bad, when all the safeguards, natural and artificial, with which they have been protected are removed, further deterioration is sure to be rapid when it once begins (47).

Female Matron, another state servant, published an account of work in prison in 1864 (48). The description of women in Brixton and Millbank is similar to that of Griffiths. They are described as "desperately wicked", "deceitful", "crafty", "malicious", "lewd" and "void of common feeling":



all the vices under the sun are exemplified in these hundreds of women, with but a sparse sprinkling of those virtues which should naturally adorn and dignify womanhood.

"For men at most differ as Heaven and earth  
But women worst and best, as Heaven and Hell"  
asserts our greatest living poet: and no two lines, I fear, are more true to human nature (49).

The four hundred women in Millbank were subjected to a strict regime and routine from 5.45A.M. when the morning bell rang, to 8.45P.M. when the lights went out. The day was punctuated with work, chapel, exercise, prayers, reading and eating. The women were productive. In 1860 they made 50,822 shirts for one city firm and mended 96,541 bags for another (50). Conversation was prohibited. Within this regimented vice the prisoners were allowed to receive one letter a month and after six months they were allowed to see their families once every three months. If they complained about those who supervised them then it was assumed that "the woman as a rule is always in the wrong and has invented the charge as an excuse to see the director" (51). Given this regime it is hardly surprising that the women presented problems and difficulties for prison managers. The use of the strait-jacket was the most common form of punishment in Millbank in 1860. This punishment was designed to cope with a range of behavioural patterns: smashing windows, barricading cells, tearing blankets, setting fire to cells and the use of secret written messages that could pass through upwards of twenty hands. In one year, there were 154 cases in which prison property was destroyed (52). Again, other strategies, over and above the strait-jacket, were mobilised to deal with the women. The use of male officers was one:

There are some male officers who can keep their temper after a scratch down the cheeks, or in the face of resistance generally made to their efforts to remove a prisoner; but there are others, not few and far between, who are cruel and vindictive, using their giant's strength tyrannously, and like a giant (53).

A second strategy consisted of removing the women to the "dark cells". There were six in Millbank. Four of the six had reinforced doors which tended to "stifle the uproarious sounds that generally proceed from them". Additionally the furniture consisted of a:

slanting series of boards by way of bedstead with an uncomfortable wooden block for a pillow - hard quarters for the worst of women and, with a bread and water diet, telling rapidly upon a prisoner's health (54).

Even here, there was resistance with continuous singing and hammering particularly when the officers were in bed. Blankets and rugs were torn, water was thrown over the matrons and food was rejected and thrown from the cell.

A third official strategy was the mobilisation of psychiatry. Female Matron talked of the "restlessness and excitability in the character" of the female prisoner which "flies in the very face of prudence and acts more often like a mad woman than a rational reflecting human being" (55). Those who engaged in "breaking out" were a particular problem. The matron saw this behaviour as "altogether distinct from the raving and violence of the inmates of a lunatic asylum and appears very often to be a motiveless fury" (56). Broadmoor which had opened in 1862

as a criminal lunatic asylum, was used for the removal of the women:

the principle is attempted there of treating all 'refractories' - women prone to break-out - as lunatics. It held the most dangerous of the 'dangerous classes' ..... (57).

The matron indicated that the women were subjected to a battery of surveillance from "observant officers, surgeons and physicians taking note of every sign of mental weakness or of every pretence thereof ...." She and the other officials felt it was difficult to know "where sanity ends and where madness is likely to begin" (58) as a number of women feigned madness, in her view for the purpose of association. Women in desperation at the regime also attempted to obtain a place in the infirmary through self-mutilation and personal damage which would mean "a few privileges and a higher scale of diet" (59). Overall, however, the matron was not impressed with those in the infirmary:

..... taking the infirmary patients altogether, there is not much difference in the character between them and their more robust sisters doing prison work. The same ingratitude, and selfishness, and callousness are evinced towards each other; and to the prison officers, the same duplicity, craft, and vindictive feeling. There are women whom nothing will soften, whom no kindness will affect (60).

Prison Matron's account provides a valuable insight into how women prisoners were regarded by state servants and particularly how the root of their criminality was conceptualised. It also shows the deep and often violent level of tension and confrontation in Millbank and the increasing intervention by medical

men to deal with it. R.F. Quinton, the M.O. at the prison described his relationship with the women in his tenure there in 1880. There were 250 women in the prison at the time. They were kept in a special block or pentagon. According to Quinton:

The governor at the time, who could manage quite successfully 600 military prisoners and 500 male convicts, was as wax in the hands of the females. If they were at all refractory, his sole idea was to hand them over to the medical officer as patients requiring medical care and treatment, and so to get them out of his jurisdiction for the time being. He seemed to have an idea that all women were mad. His plan led to friction, and did not work well. Violence frequently took on an epidemic form, and too often the female pentagon was a pandemonium (61).

He based his views on the peculiar and particular aspects of female nature contending that women drunkards were "much more hopeless to deal with than men, and that it is very difficult to wean them from evil habits". Additionally, he saw young women as "peculiarly susceptible to contaminating influences". This contamination came from confirmed female criminals who were "specially dangerous as corrupters of novices":

It is a disagreeable characteristic of some of these vicious female criminals that they seem to derive a mysterious satisfaction, amounting almost to a delight, in corrupting their younger companions. The characteristic is certainly not so common with men (62).

He had a solution to the problem of young women criminals. They should have the chance to talk to "sensible people" who would change their "vapid and silly" ideas:

unrestricted intercourse with Lady Visitors, who can give them sensible ideas and straight talks, and at

the same time show them sympathetic consideration, will be of much more practical value in effecting their moral improvement than cycles of short sentences of imprisonment (63).

For those women described as having a "weak intellect", he advocated a different kind of institutional establishment where they could be dealt with and normalised:

Female offenders who are of weak intellect will gain incalculable benefit from the scheme of the Royal Commission, which provides for their removal from prison altogether. This class - a very pitiable one - never has been, and never can be, rationally dealt with under a short sentence system. Their vicious habits and criminal propensities soon alienate them from relations and friends who, in despair of controlling them, abandon them to their fate - picking up a living on the streets. Petty thieving, drunkenness, and prostitution bring them back to prison time after time, their only gain from imprisonment being the protection it affords them for the time being from the perils of the streets, which, in the case of feeble-minded girls and women, are appalling. They need not only preventive, but protective detention in some kind of institution other than a prison for a much longer period than any term of penal sentence their offences would justify (64).

The increasing importance attached to the doctor's role in prisons for women was reflected in the appointments of medical men to head the establishments. In March 1885, the BMJ commented on the recommendation made by the Directors of the Convict Prisons to the Home Secretary that the prison for women at Woking should be placed under the charge of "an experienced medical man" (65). The writer could see no objection to this, the common response "that discipline cannot be intrusted to a medical man is frivolous" (66). This was to continue into the twentieth century. In 1909 the governor and deputy governor of Aylesbury were medical men. In 1916, another deputy governor was appointed.

She was Selina Fox, who was the first woman to hold this position. She was also a doctor. When Dr Winder, the governor was transferred, she was promoted to governor, a post she held for 3½ years. After the First World War, Dr John Hall Morton became governor of Holloway. When he died unexpectedly he was succeeded by Dr John Muir Matheson who was both governor and medical officer. In April 1927 the medical governor was assisted by two other medical officers. Both were women (67). In 1920 it was also decided to employ fully trained nurses. They were introduced by Beryl Carden who herself was a qualified nurse. She replaced prison officers in the hospital at Holloway and other women's prisons with trained nurses. The post of Nursing Matron-in-Chief was created and through this the Prison Nursing Service was established. The nursing service was linked to the Prison Commissioners by a voluntary Advisory Nursing Board (ANB) which was appointed by the Commissioners. Those involved were "mostly matrons of the large London hospitals." The ANB's role was advisory discussing with the Commissioners "the conditions of service of the nursing staff and on nursing matters generally" (68). It was not until 1945, with the appointment of Doctor Charity Taylor, that a woman became governor of Holloway (69).

Like their male counterparts, women prisoners in the late nineteenth and early twentieth century described a different reality to that articulated by prison managers. In these accounts there was a deep concern about the standard of health care and the medical treatment that women received in the harsh world of the prison. Susan Willis Fletcher's autobiographical account, Twelve Months in an English Prison, was published in 1884. Fletcher

detailed the terrible conditions in which the women lived in Westminster prison. She had three blankets which were washed once a year and a pair of sheets and a sawdust pillow which were washed once a month. She had no mattress. In winter, the cells were cold, damp and dark. Accordingly:

the healthiest nearly perish of cold. Of course they are sent there - some thousands of women every year, an average of five or six hundred at a time - to be punished, but not, I think, to have their health destroyed by being kept twenty-three hours out of every twenty-four in solitary confinement in dark, cold, damp cells, like so many tombs (70).

She described the death of a sixty year old prisoner. For the inquest a jury was "summoned from the neighbouring public houses":

The testimony of the physician was given, and, in accordance with it, a verdict of "death from old age" - old age at sixty! We who had watched her knew that she had died from the exhaustion of grief, cold, and an insufficient and inappropriate diet (71).

In 1905 Florence Maybrick published her account of the fifteen years she spent in prison. The book detailed a range of issues affecting women prisoners including solitary confinement, hard labour and the use of strip-searching by the prison authorities. She discussed the constant supervision where the prisoner was "always in sight or hearing of an officer ..... the rule of supervision is never relaxed" (72). While the prisoners were guarded and controlled by women it was men who "made the rules which regulate every movement of their forlorn lives" (73). Maybrick also described the role of the prison doctor in punishing the women. Punishment included three days solitary confinement

on bread and water with the loss of marks:

either in a strait-jacket or "hobbles." Hobbling consists in binding the wrists and ankles of a prisoner, then strapping them together behind her back. This position causes great suffering, is barbarous, and can be enforced only by the doctor's orders.

To the above was sometimes added, in violent cases, shearing and blistering of the head, or confinement in the dark cell. The dark cell was underground, and consisted of four walls, a ceiling, and a floor, with double doors, in which not a ray of light penetrated. No. 5 punishment was abolished at Aylesbury, but in that prison even to give a piece of bread to a fellow prisoner is still a punishable offence (74).

Finally, she discussed the question of medical treatment. In Woking prison, the women who were removed to the infirmary experienced a particular sense of desolation and alienation. This was compounded by the lack of nursing care:

The prisoner must attend to her own wants, and if too weak to do so, she must depend upon some other patient less ill than herself to assist her. To be sick in prison is a terrible experience. I felt acutely the contrast between former illnesses at home and the desolation and the indifference of the treatment under conditions afforded by a prison infirmary. To lie all day and night, perhaps day after day, and week after week, alone and in silence, without the touch of a friendly hand, the sound of a friendly voice, or a single expression of sympathy or interest! The misery and desolation of it all can not be described. It must be experienced. I arrived at Woking ill, and left Woking ill (75).

She concluded that "women doctors and inspectors should be appointed in all female prisons" (76).



Consolidating Professional Power.

Between 1859 and 1866 Dr Issac Baker Brown carried out a number of operations in his surgery in London. These operations revolved around the surgical practice of clitoridectomy. Madness in women, Brown believed, was caused by masturbation so that "the surgical removal of the clitoris by helping to govern themselves could halt a disease that would otherwise proceed inexorably from hysteria to spinal irritation and thence to idiocy, mania and death" (77). In the 1860s he also carried out operations for the removal of the labia and operated on girls of ten, those whom he considered idiotic, epileptic, paralytic and:

even on women with eye problems. He operated five times on women whose madness consisted of their wish to take advantage of the new Divorce Act of 1857, and found in each case that his patient returned humbly to her husband. In no case, Brown claimed, was he so certain of a cure as in nymphomania, for he had never seen a recurrence of the disease after surgery (78).

Brown's savage interventions into the lives of his patients and the ruination that followed, was based on the presumed relationship between women's sexuality and deviance. The control of that sexuality became a central concern for the male medical profession. That control turned on preventing women, especially degenerate women from procreating and at the same time introducing programmes and policies inside the walls of institutions to both regulate the body, discipline the mind and produce the industrious, sexually controlled female subject. While Lombroso published photographic studies of the faces of female degenerates, in England it was doctors such as Henry Maudsley and A.F. Tredgold

who pushed the argument forward to include not only outward physical stigmata but internal defects which could be passed on to the next generation. In 1895, Maudsley urged husbands to scrutinize their prospective wives for:

physical signs .... which betray degeneracy of stock ... any malformations of the head, face, mouth, teeth and ears. Outward defects and deformities are the visible signs of inward and invisible faults which will have their influence in breeding (79).

Dr L. Forbes Winslow contended that the "abnormal criminal woman is far more vindictive and cruel than the male" and had "badly shaped heads .... large projecting ears and flat foreheads" (80). The surgeon at Queens College Birmingham argued that the delicate skin, thin eyebrows and sharp tongue of women "made men unable to resist hitting them" (81). A.F. Tredgold outlined a typology of the morally defective which included the "facile type" mainly composed of women whom he judged to be "lacking in will power" and "unable to steer a right course" while the trouble for girls was usually sexual deviance. He maintained that around half of the girls admitted to Magdalen Homes "and a considerable proportion of prostitutes ..... belonged to this class of morally defective" (82). As Elaine Showalter points out:

Discovering physical signs provided doctors with "scientific" confirmation of the hypothesis that lunatics were actually degenerates. Contempt for the insane as evolutionary failures characterized the discourse of psychiatric Darwinism. The rhetoric of heredity, inheritance and degeneracy which appears obsessively in the medical literature of the time is also closely linked to class prejudice and to ideas of race superiority (83).

This ideology allowed for particular interventions to be made into the lives of women, both confined and otherwise, for it was they as a social group who were held responsible for the transmission of such defects from one generation to the next. At the BMA Conference in August 1900, the Psychology Section discussed the causes of insanity which included "the marriage of the neuropathic, and hereditary transmission, alcoholism and syphilis" (84). Dr MacNaughton-Jones detailed the correlation between insanity, vice and crime "and pointed out the importance of co-operation between the alienist and the gynaecologist" (85). This theme was taken up by the medical journals. In May 1904, The Lancet discussed the problems of feeble-mindedness and degeneracy. The journal argued that there was ample evidence to show that "the offspring of feeble-minded persons, both men and women, usually inherit their defectiveness in some degree and that is the way that the evil is perpetuated" (86). Two weeks previously in an article entitled Undesirable Marriage its writers had agreed with Sir James Crichton-Browne's proposal that:

large classes of the most degraded of the people should be restrained by law from possibility of propagating their kind. How this is to be done is another matter. The permanent sequestration of all imbeciles, weak-minded persons, habitual criminals, and, we would add, habitual drunkards, would be a course fraught with advantage to the community, not only in so far as it would prevent the birth of a vast number of children predestined, if only by their environment, to weakness or to crime but also by reason of the degree in which it would act as a deterrent from the first lapse into intemperance or into criminal courses (87).

Much of this debate was tied up with questions of the nation and

its well-being. Hygiene and health for the masses and the control of the feeble-minded were the twin pillars on which were built the nation's progress. As The Lancet succinctly argued:

... children should also be taught the beauty of personal hygiene and the part which it plays in the greatness of a nation .... we may safely assume that the nation which boasts the most rationally fed individuals will, in the long run, have the best chance in international struggles (88).

Women were at the centre of this debate. The Lancet described a proposal by the National League for Physical Education and Improvement where each branch was to encourage all agencies in its own district:

which have for their object the promotion of physical well-being, to instruct mothers in the feeding and care of their children, to see that adequate opportunities are available for open-air games and physical exercises for boys and girls, and, in fact, to foster all efforts to improve the general health and physique of the people (89).

Inside the walls, policies and programmes were also introduced to regulate the sexuality of degenerate and deviant women. At Broadmoor, women convicted of infanticide were detained until the menopause had occurred (90). In its 1904/5 session the Transactions of the Medico-Legal Society reported on a meeting that had taken place under the general rubric of "the proposed sterilization of certain degenerates". Sir James McDougall told the assembled men that some physical means "should be adopted to prevent 'degenerates' from propagating their like." While Bernard Shaw raised questions about the ignorance of the medical profession

in this matter, the mood of the majority of speakers favoured some form of direct action including removing degenerates to a "colonial situation" and sterilization (91). Arnold White pointed out that he had recommended the sterilization of the unfit nearly two decades earlier. He had visited a number of different countries and concluded that Britain's sovereignty in the world would be ended by 1925 "unless something practical was done to reduce the number of inefficient" (92). Dr Robert Rentoul was more specific:

Degenerates who desired to marry should be sterilized after a written direction by the Commissioner of Lunacy. The necessary operation was continually and legitimately performed now to protect the personal health of the man or the woman concerned. It should be voluntary, in the case of the sane - here vasectomy would suffice; with the insane it should be compulsory - spermectomy. The sterilizing effects of X rays were considered. A heavy punishment should be inflicted if notice of previous sterilization was withheld from the other party to the marriage. Dr Rentoul exhibited an elaborate series of diagrams and tables in support of his thesis (93).

Rentoul had published a book in 1903. It was titled Proposed Sterilization of Certain Mental and Physical Degenerates. He was quite clear about the way forward for the society. There should be compulsory sterilization for the 107,944 inmates in lunatic asylums. Additionally, all those suffering from congenital heart and lung disease, venereal diseases, plus "the 36,000 to 50,000 tramps and the 60,000 prostitutes who had so manifestly shown their mental defectiveness through their choice of life-style and profession" (94). In 1910 Winston Churchill, the then Home Secretary wrote to the Prime Minister pointing to:

the 'multiplication of the unfit' which clearly constituted such 'a very terrible danger to the race'. Until the British public accepted a policy of sterilisation of the unfit it was Churchill's opinion that the feeble-minded would in the public interest have to be segregated both from the general public and from the opposite sex (95).

William Bateson, Professor of Biology at Cambridge, was more forceful in his imagery. In 1914 he wrote that in relation to the feeble-minded:

The union of such social vermin we should no more permit than we should allow parasites to breed on our bodies ... Further than that in restraint of marriage we ought not to go, at least not yet (96).

In 1906, Aylesbury prison was established as an institution for weak-minded women (97). The establishment of this institution had been preceded two years previously by the appointment of The Royal Commission on the Care and Control of the Feeble-Minded. The Commission reported in 1908 and was deeply concerned with the problem of feeble-minded women. Harvey Simmons has pointed out that not only did the Commission assume mental deficiency was inherited but "equally important that feeble-minded women were more fecund than normal women" (98). This fear of biological reproduction was itself underpinned by the deep threat these women were felt to pose to "existing middle-class and respectable working class notions of sexuality and familial morality. This explains the near hysteria which characterizes discussions about the social problem of mentally deficient women" (99). Once again A.F. Tredgold was an important figure here particularly in relation to the statistics he

produced regarding the average number of births born to degenerate families as opposed to 'normal' families. In the former case he argued that 7.3 children on average were born, in the latter it was 4. According to Simmons, the Royal Commission "accepted these findings and concluded that the number of children born to mentally defective parents is abnormally high. The Times endorsed this view" (100). The role of women in the process of transmitting degeneracy was captured by A. Lyttelton in the debate over the Feeble-Minded Persons Control Bill submitted to Parliament in 1912:

These women have no control over themselves. In the summer months when they go out they are a source of temptation, and they are the prey of dissolute minded men. They transmit loathsome diseases throughout the country, and year after year, they reappear in the winter at the work-houses, and give birth to children begotten by parents, from time to time who are unsound (101).

The Eugenics Education Society was an important focal point for the dissemination of these ideas. Founded in 1907, it had by 1913-14 over 1,000 members. At the International Eugenics Congress in London in 1912, A.J. Balfour and Winston Churchill were included in the list of Vice Presidents of the Congress (102). The leadership of the society was dominated by the educated middle class, particularly from the fields of medicine, university teaching and science. As Donald MacKenzie points out:

.... the bulk of its activists were of the professional middle class. Business and the hereditary aristocracy (as distinct from ennobled commoners) were not prominent in support of eugenics in or out of the society. Nor were the working class. It would also seem clear that the eugenicists were not recruited equally from all sections of the professional middle class. The

universities, science and medicine are all highly represented; law and church more sparsely. Finally it is of interest to note that women are highly represented in the F.E.S. (forming, for example, a majority of its total members in 1913) (103).

The Society was concerned about the decline in Britain's imperial role. Its members felt that the nation was being undermined from within by the residuum which threatened to contaminate the respectable working class. At the same time the residuum also posed a threat because of the increase in its numbers due largely to advances in medical science, sanitary reform and the operation of charity. These advances had led:

to the flourishing in the hearts of the great cities of a group of people tainted by hereditary defect. They were unemployed because they lacked the health, ability and strength of will to work. Hereditary weakness turned them to crime and alcohol. Their constitutions inclined them to wasting diseases such as tuberculosis. This group of degenerates was out-breeding skilled workers and the professional middle class. Further, the eugenists warned, although natural selection was largely suspended within British society, competition between different nations went on. Britain was engaged in a struggle for survival that was at present commercial but might become military. National fitness for this struggle was necessary. This had previously been ensured by natural selection, but under the conditions of modern civilization a replacement for natural selection had to be found in conscious eugenic selection. A pliable and fit working class could be bred by isolating the residuum in institutions where parenthood would be made impossible. Negative eugenics was thus not an abstract programme, but a specific response to a specific problem. The eugenists proposed the most thorough solution to the problem of the residuum short of immediate elimination. Social control was to be imposed by the detention in institutions of the habitual criminal, the alcoholic, the 'hereditary' pauper, and so on. Prevention of parenthood in these institutions would mean the eventual disappearance of the residuum as a group. This solution would leave untouched the position and privileges of the higher social classes, while drawing in full on the skills of the middle class scientific expert. While it



might seem a rather extreme proposal, it differed only in thoroughness and scientific rationale from similar proposals put forward at the time, for example, for labour camps with compulsory powers of detention (proposals that were supported by Fabians and 'humanitarian' Liberals) (104).

As Mackenzie makes clear it is important to see the links between these proposals and the development of rationalised systems of mental testing in the post World War I period. Eugenists such as Francis Galton and Karl Pearson aimed for "the provision of a rationalised system for ensuring that occupational positions at the various levels of the hierarchical division of labour were adequately filled." These theorists sensed that:

highly technological monopoly capitalist society would need a planned and selected supply of labour, rather than the chaotically competitive labour market of early capitalism. As Gary Werskey has pointed out to me, this need was largely met after the First World War by the widespread use of IQ tests, the development of the three-tier secondary education system, and so on. While not involving eugenically planned reproduction, these developments did in fact have strong connections with eugenics (for example, the role of the eugenicist Cyril Burt in pioneering the introduction of mental testing) (105).

Burt published The Young Delinquent in 1919 which "was widely read and went through several printings" (106). He paid particular attention to the deviance of girls, arguing that women were ruled by their biology. Delinquency in girls could be explained "by the onset of puberty and periodicity":

The impact of periodicity which appears to affect a vast amount of a woman's life, compels them to 'roam the streets accosting strange men in fantasy' and outbreaks of temper, are exceedingly frequent ..... He also saw sexually active young women as extraordinarily dangerous. They were viewed as a threat to community morality and to the reputation

of 'innocent' adult males. Not all delinquent girls were of this 'dangerous' nature, but for those who were, hard work and physical exercise was recommended (107).

He supported segregation. For those female delinquents who were not dangerous there should be "temporary segregation in training colonies operated like a 'normal family .... with grown house parents ....'" (108).

Burt was not the only social scientist committed to such an explanation of social problems. Eugenics was a central element in the founding of the Sociological Society and by extension of academic sociology in Britain. Although challenged by figures such as L.T. Hobhouse, who was the first Professor of Sociology at London University, nonetheless "eugenics, by virtue of taking human evolution as its central concern, was taken very seriously by those social scientists who were convinced that an evolutionary model needed to be used in social sciences" (109).

In his study of the development of psychology between 1869 and 1939, Nikolas Rose sets these developments in their political and institutional context. He argues that the eugenic strategy provided the conditions which allowed the question of feeble-mindedness "to take the form that it did and to offer to psychological discourse a particular object around which it would begin to regularize and institutionalise itself as a practice" (110). He goes on to point out that this strategy was one element in the struggle around the nature, objectives and practices of social policy. This is an important point, for as he argues, there were other discourses operating and challenging the

philosophy and strategy of the eugenics movement. In particular, there was the question of the environment, developing around the strategy of social hygiene "which found its principal spokesmen in the doctors and which utilised as evidence the results of a tradition of social investigation concerning the interaction of environment and health" (111). Doctors through journals such as the BMJ proposed interventions in the lives of the poor, "breaking down ..... the opaque masses ... into visible units" and instigating "action upon the efficiency of the population at the level of the household through its transformation into a technical machine for the rearing of healthy children." As he concludes:

The eugenic and the neo-hygienist strategy appear to be in opposition. The former proposed segregation, the latter socialisation, the attachment back to the social order of those groupings who were marginal to society because they had escaped its norms. Eugenics operated in terms of a rigid policing of the boundary between those in society and those who threatened it; medicine operated by attempting to integrate the diseased affected through education and the inculcation of norms. But this opposition was by no means an absolute one: not only could these strategies be combined into a single schema of administration, but such a schema illustrates exactly the key point at which an individual psychology was to try to establish itself. For what became central were techniques of individuation and assessment which would enable a rational distribution of individuals, amongst a variety of social institutions and practices specialised to deal with them according to their personal characteristics, problems and difficulties in order to produce the most efficient and productive population (112).

Rose's point is encapsulated by the editorial in The Lancet in April 1905. The journal was circumspect in calling for all-out eugenic intervention fearing that in the present state of knowledge it would be "hazardous" to simply interfere with

individual lives. This circumspection, however, allowed the writer to call for a more general level of intervention which did not preclude eugenics but which he hoped "might raise the moral and the physical condition of the masses ... [and] if so raised would in time supply the country with children prepared for still further advances in the same direction" (113). The writer went on:

We may, in short, treat the genesis of the coming race on such principles as to justify a hope in the gradual improvement of mediocrity, in whatever station of life it may be found, and the gradual improvement of mediocrity will be likely at once to push up those who are above and to drag up those who are below. The influence must, we think, be exerted rather upon the community than upon individuals ..... (114).

This emphasis on the "community" in Foucault's terms a "biopolitics of the population" meant, in practice, a series of interventions such as the establishment of special schools for feeble-minded children. By 1903 these schools had been established in London and 50 other authorities (115). At the same time, the attribution of physical signs and bodily shapes to criminality and deviance declined still further and instead the link between mental powers and behaviour was increasingly emphasised. Modes of assessment, as pioneered by Alfred Binet in France set the parameters for the debates on intelligence. The Binet-Simon test as it became known held out the promise of quantifying intelligence. As Rose points out:

The test held a potent promise in its ability to transform previously unmanageable attributes into assessable calculable quantities. The first extension was from the pathological to the normal. What

was originally a device for diagnosing the defective became a device for hierarchising the normal. The reference which the condensation of behaviours into a single number appeared to make to a hidden quality of the individual, together with the norms of development which provided the standard of assessment of deficiency, made it easy for the test to be extended beyond its initial point of emergence (116).

In the women's prisons, the quantification of behaviour was reflected in the work of W.C. Sullivan, the M.O. at Holloway. He visited Binet to study his method for measuring intelligence and produced his results in a paper in The Lancet in March 1912 (117). Sullivan did not see the test as a substitute for complete clinical study. He did, however, feel that "it supplements the clinical investigation and enables its results, so far as the factor of intelligence is concerned, to be presented with a clearness and an objectivity which must considerably enhance their value" (118). By 1921 Sullivan had become the Medical Superintendent at Broadmoor and lectured at London University on a post-graduate course in mental deficiency. He reiterated his view that the "critical study of individual cases" (119) was the basis for analysing and responding to the criminal. The next month in the same journal Dr Norwood East, the Senior Medical Officer at Brixton, provided an individual case study of a moral imbecile called Jane. Not surprisingly, he found a history of "early sexual delinquencies". It is clear, he wrote, that from "an early age she possessed a personality which fascinated those men she elected to attract; and this fascination remained with her in later years" (120). From there she moved to impersonations and swindling, arson, theft and bigamy through which she managed five marriages. East was quite clear in his conclusions after his studied observation of the woman:

The instincts of sex, acquisition and exhibition are uncontrolled, and result in sex immorality, fraud, and theft in the wearing of her hair in a long false plait, and in her exalted impersonations. The maternal instinct is defective, the social instinct, which should express itself in a desire for companionship, in consideration for and duty towards other members of the community is underdeveloped .... (121).

This individualisation through the measurement of character or temperament meant that prison medicine and psychology developed a "behavioural rather than a therapeutic rationale for detention" (122). At the same time, it increased the level of probing, testing and surveillance strategies to which criminal women were exposed. Importantly, this surveillance and the drive to normalisation that underpinned it was based on an inter-related network of professional and class power. Women prisoners were the object of a range of strategies, more intensive and well-developed than those to which male prisoners were subjected. The strategies met on the same policy terrain, saving the soul of the deviant woman for the heaven of normal motherhood.

#### Surveillance and the Deviant.

For women prisoners, the question of their rehabilitation at the turn of the century was built not only on the observations of doctors and chaplains but was also related to personal surveillance from the women of the landed gentry. These successors to Elizabeth Fry carried on her work of intervening into the lives of imprisoned women with a view to changing their habits,

doctoring their souls and returning them to their rightful family place. As Prison Matron points out, the women in Millbank in the 1860s were visited by "lady visitors who may be termed professionals ...." (123). These women assisted the Scripture-reader, the chaplain and the school mistress. The visitors' efforts extended to outside the walls where they provided advice, money and, in some cases, homes. In 1901, the Lady Visitors Association was formed. Its president and guiding light was Adeline, the Duchess of Bedford who in turn was succeeded by the Hon. Lady Cecilia Cunliffe (124). The Association was described as "a body of earnest and devoted ladies with experience of rescue work and a keen sympathy even for the most degraded of their sex" (125). The Duchess of Bedford regularly visited Aylesbury prison and it was "on her advice that the first trained nurse was appointed to the Prison Service" (126). The Lancet felt that the Association had done "magnificent work in persuading convicts who have expiated their offences to desire a better life" (127). The journal set this praise in the context of the "psychical fact that a woman criminal is far more difficult to reclaim than a man ...." (128). More generally, its writers believed that the classes introduced in Portsmouth prison which were based on lectures around nursing, the care of children and hygiene were to be supported not only because of the subject matter but also because they acted as an incentive to good conduct. It concluded:

The ignorance of the poorer classes about the management of their houses and their children, about hygiene, and about housekeeping is, after 35 years of compulsory education, simply astounding and anything which will tend to remove this ignorance is to be welcomed. Miss Smith-Rossie

expresses a hope that such lectures will be initiated in every local prison and we echo her wish (129).

Mary Size described how she saw the dynamics of these meetings:

At the first meeting she introduces herself in a cheerful kindly manner and puts the woman at ease. They discuss everyday things that concern the housewife; cost of living, fluctuating prices and so forth. A friendship is established at the first meeting usually, and afterwards visits become events to which the woman looks forward. During the ensuing period the woman generally thinks up what she will discuss with her visitor next time. She collects the letters and photographs of her family to show the visitor. These create topics of conversation for the woman, and incidentally give the visitor an insight into the character of the home and the relationship between the woman and her family. Other subjects of conversation may be the cinema, library books, handicrafts, examinations in domestic subjects, or dress-making, etc. I have often heard peals of laughter coming from the visiting rooms, and sometimes bumped into women rushing off to class after their visits, wreathed in smiles and obviously happy (130).

Size was writing about a period when large numbers of women were sent to prison for short periods of time. In 1908, more than 40,000 women had been sentenced but of these only 362 had received sentences of more than six months. Over 30,000 were sentenced to two weeks or less. As she comments "out of these 40,000 women three-fourths had been previously convicted and approximately the same percentage had not had more than two weeks' imprisonment" (131). Size attributed the decline in the numbers after this period to the fact that the women were allowed to pay fines and to the introduction of old age pensions which meant:

fewer women were committed to prison for begging,



wandering abroad without visible means of subsistence, hawking without a licence etc. They managed somehow to eke out an existence without breaking the law. The pittance of 10/- [50p] a week gave them a feeling of independence which they had not known before, and encouraged a self-respect that they would not forfeit by going to prison (132).

As I have indicated the work of the voluntary associations extended beyond the prison walls. In February 1902 Holloway became a prison for women only. By 1922 Lady Carter, Lady Humphries and Mrs Younger had formed the Holloway Discharged Prisoners' Aid Society (133). They were "intensely interested in the welfare of the ex-prisoners ...." The annual meeting of the Society was always held at the Mansion House where as Size points out:

The Lord Mayor is its president and almost invariably takes the chair at these meetings. This indicates the importance which high authorities place on the work of rehabilitating prisoners who have served a prison sentence (134).

Walton prison, in Liverpool, had a flourishing society which operated under the title of The Liverpool South West Lancashire and Wirral Discharged Prisoners' Aid Society. Its patron was the Earl of Derby, its president the Lord Mayor of Liverpool and among its 12 vice presidents were the Lord Bishop of Liverpool, Sir Thomas Hughes and the Mayors of Birkenhead, Bootle, Southport, Wallasey, Widnes and Wigan (135). Its committee consisted of the 12 visiting justices of the prison plus representatives from the Church of England Temperance Society and the Catholic Aid Society. Additionally the Chief Constable of Liverpool and the prison chaplain were also members. Rule 2 of the society

was clear. Its object was to "aid deserving prisoners on their discharge from Liverpool prison and those discharged from other prisons having local claims." Subsection 2 of the rule indicated that women and girls would be aided by being placed "in suitable homes and refuges and finding situations for them where possible" (136). In 1916 it placed 41% of women who came to them in employment including domestic service, factories, charring, shopwork and weaving (137). It is clear however, that the prisoners especially the younger ones resisted the overtures of the society. In his address to its annual meeting in 1913, Mr Justice Bailhuche suggested that "as the proportion of the female prisoners who were doing badly was greater than the proportion of males, the Society might give special attention to young women on their leaving prison" (138). The Reports point to groups of young women simply refusing the Society's help and going their own way.

For those women sent to prison, discipline was hard and uncompromising. The day started in the convict prisons at 6.30a.m. and "with rigid regularity the time-table was adhered to day in, day out, for years without variation. She knew exactly what she would find in her dinner tin at noon each day. Her breakfast and her supper never varied. The majority wore the same style of dress year after year" (139). This discipline was underpinned by interventions by outsiders coming into the prisons and instructing the women on the process of motherhood. As I have indicated, in August 1904, The Lancet commented favourably on lectures given by Miss Charlotte Smith-Rossie to women in Portsmouth jail. The lectures were concerned with hygiene

and the care of children and were particularly directed at women imprisoned for cruelty to children. The journal supported Rossie's argument that such women should be placed in a separate class from the ordinary criminal:

as for the most part they are respectable married women and an attempt should be made to teach them home duties. This we think is a good suggestion for the average modern woman is singularly ignorant of home duties and the commonest laws of health ... If Miss Rossie would add to her labours in the instruction of prisoners by instructing those outside prisons as well, avoiding, of course, medical questions, she would be deserving of the gratitude of many (140).

In 1914, the National Hygiene League for the Suppression of Juvenile Smoking, Drinking, Gambling etc. and for the National Physical Training of the Young also offered to provide speakers to address prisoners of both sexes. The League's principles as outlined in the Young Health Crusaders' Monthly was related to notions of fitness and Empire. The President of the National Hygiene League was the Rt. Hon. Lord Charles Beresford who told the Crusaders' Monthly:

Physical exercises produce a healthy body; a healthy body produces a healthy mind, two great necessities for the welfare of our people and the Empire (141).

The Lord Chancellor in an address to the National Union of Teachers also pointed out that "it is a question of National Safety and nothing else with which we are dealing" (142). In 1922 the Prison Commissioners, in co-operation with the Adult Education Committee of the Board of Education, organized an

adult education scheme based on voluntary teachers. An educational adviser was appointed to each prison whose job was to help the governor to construct a syllabus and employ teachers. Within the scheme, there was to be a weekly lecture lasting one hour:

These lectures came from the medical profession, from universities, high schools and from domestic science centres; there were social workers also, who spoke on health, housing, nursing and citizenship .... Two voluntary teachers conducted a class of twelve women in embroidery, quilting and children's dressmaking. The senior officer in the work-room acted as a voluntary teacher and taught advanced needlework and dressmaking. I conducted a leather class. All classes were purely voluntary, but practically all the convict women wanted to attend them (143).

In March of the same year, the Commissioners announced that they "cordially" supported a suggestion by Miss Olga Nethersole of the People's League of Health for a series of lectures in London's prisons. Doctors were involved at a number of prisons and Borstals lecturing on elementary principles of health and the body. On 12th March, Col. Knox of the Prison Commissioners wrote to Miss Nethersole and emphasised that one of the chief difficulties which the Prison Commissioners had with her proposal for the series was that:

the lectures must be on the simplest lines. There are but few of our population who even understand what psychology means and whose only idea of "Health" is to have a beano and sleep it off (144).

It was also felt that lectures on health led to introspection among the prisoners and to a rise in the numbers complaining

sick. The League itself had wider objectives and principles. It emphasised the importance of heredity, the transmission of hereditary defects, the selection of suitable and healthy partners in marriage, the importance of worthy and responsible parenthood, the care of mental defectives, the use and abuse of alcohol and its relation to crime and disease and physiological and environmental influences on the human organism. In its first annual report it emphasised the fact that:

Heredity and Environment are the two determining factors in our lives, and that proper environment may be a controlling force of inherited weakness - moral and physical. We have used every effort within our means to bring to the understanding of the people what Professor Sir Arthur Keith, has described as the 'Galton Ladder' whereby if a nation wills, it can climb to a higher estate of both mind and body. We have shown that the rungs of that ladder are fashioned out of the laws of heredity, the laws which transmit physical and mental characteristics from one generation to another (145).

From the prisoners' point of view, this hygienist philosophy and practice and the medical education that flowed from it provided no answer to the problems that they experienced either inside or outside in terms of their objective position in the gender stratification of English society. It was also clear that despite official discourse, many women prisoners were not prepared to accept the prison regime and raised serious questions about its impact on their lives. This often involved questioning the standards of medical care and medical treatment inside.

Some of the earliest and most bitter conflicts in the twentieth century centred on the medical treatment of suffragette women, particularly those who went on hunger strike. The first hunger

striker was Wallace Dunlop who began her strike in July 1908 (146). This was the prelude to a series of disturbances and conflicts with the women refusing to be searched or to wear prison clothes. In 1909, fourteen women went on hunger strike, six were subsequently released on medical grounds. For those that remained force-feeding was used, with the P.M.O. at the forefront of the conflict. The first in line were nine women in Winson Green, Birmingham. In her memoirs, published in 1914, Lady Constance Lytton, gave a chilling account of the procedure involved at Walton in Liverpool:

*The doctor offered me the choice of a wooden or steel gag; he explained elaborately, as he did on most subsequent occasions, that the steel gag would hurt and the wooden one not, and he urged me not to force him to use the steel gag. But I did not speak nor open my mouth, so that after playing about for a moment or two with the wooden one he finally had recourse to the steel. He seemed annoyed at my resistance and he broke into a temper as he plied my teeth with the steel implement. He found that on either side at the back I had false teeth mounted on a bridge which did not take out. The superintending wardress asked if I had any false teeth, if so, that they must be taken out; I made no answer and the process went on. He dug his instrument down on to the sham tooth, it pressed fearfully on the gum. He said if I resisted so much with my teeth, he would have to feed me through the nose. The pain of it was intense and at last I must have given way for he got the gag between my teeth, when he proceeded to turn it much more than necessary until my jaws were fastened wide apart, far more than they could go naturally. Then he put down my throat a tube which seemed to me too wide and was something like four feet in length. The irritation of the tube was excessive. I choked the moment it touched my throat until it had got down. Then the food was poured in quickly; it made me sick a few seconds after it was down and the action of the sickness made my body and legs double up, but the wardresses instantly pressed back my head and the doctor leant on my knees. The horror of it was more than I can describe. I was sick over the doctor and wardresses, and it seemed a long time before they took the tube out. As the doctor left he gave me a slap on the cheek, not violently, but, as it were, to express his contemptuous disapproval, and he seemed to take for*

granted that my distress was assumed (147).

In his memoirs published in 1932, Lt. Colonel C.E.F. Rich, the governor of Walton at the time of the hunger strikes, described his feelings about the struggles of the women:

But what of the Suffragettes? I cannot accept the view that a political motive gives any one a privileged position in regard to the law, and it is a mystery to me why these fanatical women were allowed to escape the just punishment they had earned merely because they would not take ordinary sustenance. Why not have simply given them food and left to them the question of taking or refusing it? Had one succumbed there would never have been another ....

I often wonder whether women are any happier for having achieved so-called sex-equality. They seem to me to have lost a great deal of the respect and consideration which used to be accorded them, and really one cannot be surprised at this. It is appalling sometimes to be in court and see it packed with young women listening to cases of the most unsavoury nature, even after the judge has advised them to leave. In the old days, of course, he used to order them to go .....

To return to the Suffragettes, ..... I referred to them chiefly because of the wholly unnecessary suffering the misguided creatures used to bring upon prison officials, who carried out with the utmost kindness the unpleasant duties thrust upon them, only to be roundly abused by many busy-bodies who had little or no knowledge of the real facts (148).

The controversy over the medical treatment of the suffragettes spilled over into the general question of the adequacy of such treatment for the confined. In May 1919, the Duchess of Bedford chaired a Committee of Inquiry into "various matters concerning Holloway" (149). The Duchess was concerned about what she termed "Arrangements for Medical and Nursing Care." There was no ambulance at the prison. There was a lack of trained nursing care which was "a serious defect in the prison administration" (150).

This could have fatal consequences. In Appendix 2 of its report, the Committee outlined the cases of two prisoners who died in custody. Ellen Sullivan, a seventeen year old remandee, who was  $6\frac{1}{2}$  months pregnant, was continually vomiting. On being removed to the hospital she was "attended by the wardresses on duty at the hospital, of whom not one was a trained nurse". She was eventually left with an officer with only a few months experience:

At about 3.15 a.m. on the morning of January 18th, this officer noticed the girl Sullivan on the night-chair. She got her back to bed, and gave her some milk. The patient made no complaint of pain, and nothing was to be seen in the night-chair. The officer then went upstairs in the ordinary course of her patrol duties and on returning a few minutes later found the patient again out of bed and on the night-chair. This time she suspected something wrong and roused the day hospital officer who slept on the upper floor, having to leave the patient to do so.

On returning to her she found she had given birth to a child. The child had fallen on the wood floor of the cell, the cord being ruptured by the fall. The officer got the patient, who was still on the night-chair, back to bed and picked up the child. She then left her to the day officer while she summoned the midwife and doctor. The child lived only for a few minutes and was dead when the midwife arrived (151).

The prisoner died the following evening. She had been remanded for using insulting language in a public place and had been refused bail "because the magistrate could see no reason for granting it" (152).

In the second case, nineteen year old Rose Land was serving two months for theft. On the morning of her discharge she became ill. It was decided to take her to an outside hospital. One hospital refused to admit her while a second could not obtain



an ambulance. After three hours, the prisoner was taken by cab to hospital as her condition was "becoming rapidly worse":

On arrival at the Infirmary at 8.15 p.m. the girl was in a state of collapse and no operative treatment was considered possible. She died at 2 a.m. the next morning. The post mortem examination showed death to have been caused by intestinal obstruction from inflammatory glands constricting the ileum about 6 inches from the ileo-coecal valve (153).

The Prison Commissioners wrote to the governor of Holloway about the report:

The section of the report dealing with verminous and dirty conditions should be carefully noted. It is evident that there has been a want of care and thought amounting to neglect in these matters .... the Commissioners must express their great regret that it has been necessary for them to admit that certain irregularities have crept into the administration of Holloway in essential matters eg due segregation of convicted and remands, cleanliness, clothing etc (154).

Prisoners themselves took other action. The report by the Prison Commissioners for 1923 pointed to "smashings-up" at Aylesbury Borstal (156). In the same year, Jane Cormack brought an action against the Home Office for being illegally detained in an asylum. One of the points in the writ was that she was forcibly conveyed to Hellingly Asylum where:

she was detained for about one year .....  
drugging her several times a day with force intent  
to deprive her of sound reason, judgement etc (156).

When the report of the Prison System Enquiry Committee was published in 1922, the authors Stephen Hobhouse and Fenner Brockway

devoted a chapter to the position of women in the prison system. In their introduction to the chapter they argued that at a general level there was no radical difference between prisons for men and women:

The same repressive system, the same idea of punishment, with almost no thought of cure, runs through both systems. The wastefulness, the failure to individualise, the lack of serious training and the cruelty which comes from looking upon people merely as bodies instead of as personalities are found in both. In both there are the small, nameless humiliations, the inevitable abuses, or a too-absolute power, and the infringements of rules to the prisoners' disadvantage (157).

The Committee found the most common form of crime committed by women was drunkenness with aggravation followed by prostitution, offences against public regulations, simple drunkenness, simple larceny and assaults. It also discovered that magistrates were using the prisons to sentence prostitutes for compulsory examinations and treatment for venereal disease. Such women would ordinarily have been released on bail, fined or discharged. Sentences, the Committee felt, were too short for effective treatment:

All the evidence goes to show that even those women who serve their full sentence go out but little improved in health, and soon return worse than before .... The recognition of the futility of short sentences has led to a deplorable custom. Some magistrates, instead of passing sentence on a woman suffering from V.D., remand her from week to week for treatment - a grave evasion of the safeguards of personal liberty (158).

The figures for remands supported this point. In 1919, 4,511 women were remanded. Of these 1,622 (36%) were sent to prison

while 2,889 (64%) were either acquitted or were given a non-custodial sentence. Accounts by women prisoners indicated how the remand process was being used. Two who had been arrested during Easter 1917 for "using insulting words or behaviour" were remanded in Holloway "with definite instructions from the magistrates that they were to be examined for venereal disease, bail being refused until the result of the examination was known". The women had two medical examinations, the ordinary one and then a full internal and external examination:

On Thursday (April 12th), after we had been in prison two days, we were sent to the doctor and were both stripped of everything except our chemises. My friend was examined first and I found her crying. The nurse said 'K----- is all right'. Then I was told to lie down on my side and take off my chemise. The doctor and the nurse examined me and the nurse called attention to where I had been torn when my baby was born (159).

For convict women serving long sentences, these processes were significantly intensified. They frequently complained of hunger, there was little variation in the food intake and they spent 18 hours out of every 24 in the confinement of their cell. The allowance of one third remission (as opposed to one quarter for men), their daily gratuity and the privilege of spending the last 9 months of a sentence (if well-behaved) in an approved refuge or home were scant consolation for the pressure of the daily regime.

Other prisoners complained of the lack of privacy and the fact that little attention was paid to the special medical needs of

women during menstruation. At a conference organized by the Penal Reform League in June 1917, one ex-prisoner captured the relationship between the women and the all-male network of power with which they were confronted:

Owing to prison negligence I became ill and only left my cell for four hours' exercise on four different days - during the whole of my sentence. My cell was, therefore my dining-room, my bedroom, my bathroom, and my water-closet, and I was always just in my nightdress. I must, of course, leave a good deal to your imagination, but can you realise what it meant when the male governor, male deputy-governor, male doctors, male chaplains, male visiting magistrates, male inspector, all apparently have the right to plunge into your cell-bedroom without the slightest warning, or even knocking, or even asking your permission! The wardress certainly unlocks the cell for these men, her superiors; but as you seldom hear their approach, and practice has made her a lightning-speed key-fitter, a prisoner may be caught in the most embarrassing situations. I do not want to labour the point, but I say that there is not one woman in this audience -whether single or married - who would like to think that any strange man could burst into her bedroom in that way (160).

The report by the Prison System Enquiry Committee was a crucial document for raising the issues around the prisons. The breadth of its research and the fact that it allowed the prisoners to articulate their views and feelings about life inside stood in marked contrast to official accounts of the day, accounts which as Chapter 4 indicated had become even more restricted with the passing of the 1877 Prison Act. However, despite the radical thrust of the report, it too could also fall into stereotyping the lives and behaviour of confined women. Thus in discussing cruelty to children, the authors pinpointed its causes as lying in "utter neglect, ignorance and bad conditions" and complained that in the present system "no real effort is made to give such

women any training in home duties" (161). Similarly, when discussing criminality in general the report noted:

as a rule the medical officers of prisons do not appear to be encouraged to use their position with a view to research into the immensely important bearing of physical conditions upon crime. In view of the fact that the emotions are so profoundly affected by the sex instinct, it might reasonably be supposed that the incidence of crime, particularly of those forms of it which are more directly associated with emotional instability, would vary with the condition of the sexual life. It should be a comparatively simple matter to elucidate some of the effects of this element in the causation of crime in women owing to the definite monthly cycle of the sexual life (162).

There were critical voices raised from other, more unexpected sources. One of the strongest was Mary Gordon, who was the first female Inspector of Prisons. She held the post for 10 years and after her retirement published Penal Discipline in 1922. Gordon was critical of a number of aspects of women's imprisonment. She was opposed to the compulsory examination of women for venereal disease. She introduced improved lighting and ventilation and substituted clear glass for the opaque variety in the windows (163). She also raised some serious questions about the relationship between prisoners and prison doctors. This included the fact that there was no confidentiality between the doctor and the prisoner in that the doctor could take a prisoner's secrets and "give them to the Governor of the Prison, the police, the court. The prisoner does not consult the doctor, the State pays the doctor and consults him about the prisoner." Additionally, the doctor's official position meant:

he is a constable as well as a doctor. He is endowed with very special powers over the patient's life. He is one, and a very important one, of his gaolers. He decides upon his fitness for work, fitness for dietary punishment, fitness for restraint. If corporal punishment is awarded he certifies the prisoner fit, supervises the punishment, and can stay it. He forcibly feeds the prisoner to prevent his determining his imprisonment, stops when he thinks he has done as much as he dare, carries out the "cat and mouse" regulation. He is there when the prisoner is hanged. None of these disciplinary or penal events would ever be carried out at all, except under his aegis, and, but for his help, this part of penal discipline would absolutely disappear. If it is argued that he is there on the prisoner's behalf to see that he is as little injured as possible, nevertheless, he is the person who makes what happens possible. His is, therefore, very much the heaviest hand over the prisoner in the affair of penal discipline (164).

That "heaviest hand" could lead doctors into areas where their ethical code concerning the protection of life was compromised. In 1923 Edith Thompson was sentenced to hang for murder. Her lover had murdered her husband in a plot of which she had no knowledge. She was seen "as an adulterous femme fatale urging her young lover to dispose of an unwanted husband, a view that the trial judge was only too happy to endorse" (165). Immediately before the execution, John Hall Morton the prison governor and Medical Officer, dealt with the prisoner's distraught protests by injecting her with drugs "1/100 grain of Scopalmine-Morphine (Purlight-sleep) and 1/6 grain of morphia" (166). She was carried to the scaffold and propped up on the trap door so that the noose could be fixed to her neck.

Despite her critique of the P.M.S., Mary Gordon was clearly committed to the use of imprisonment for offenders. It was the principles on which confinement was based that she wished

to challenge. While she was "on the side of firm discipline" (167) she did not believe that a repressive, uniform regime could do much for the thousands of petty offenders who were incarcerated each year. It was a "very expensive absurdity" (168). She wanted a much more individualised approach to criminality at the centre of which would stand medical psychology. For the "drunken dissolute woman .... we want our doctor to study and unravel her problem":

What of the woman who has murdered her child because there is a man who does not want the child? Are we to shut her up for 16 hours a day, for an indefinite number of years, with nothing to think of except how badly she managed that she was found out, and how much less of a fool she will be next time - built on this time? Or shall we give her the doctor or educator who can show her where she is, and bring her to herself? (169).

The Lancet supported her views on "the importance of substituting the spirit and methods of medical science for the rigidity of military and bureaucratic 'systems'" (170). So too did Calvert and Calvert whose study, The Lawbreaker was published in 1933. The Calverts discussed the women's prison of the future and cited the recently published report by The Departmental Committee on the Treatment of Persistent Offenders. The Committee had called for the establishment of "a building of the non-prison type" for selected numbers of detained women:

As a start, an old country house might be acquired for the purpose at a reasonable price. If numbers permitted, two or more institutions might be set up, which would allow of more effective classification and training. The experiment would start with the advantages that training in useful employments is easier with women than with men, and that detention in an institution other than a prison would avoid

the complete loss of self-respect which women frequently suffer as a result of imprisonment (171).

They argued for the construction of two "modern institutions", each holding 150 women. The institutions would be built on the "cottage" principle, have small, self-contained units and accommodate between 20 and 30 women. This would enable:

the authorities to classify the offenders adequately, and the domestic work of each house would provide a good all-round training in house-work. There should be no wall and a minimum of locked doors. The buildings and equipment should be as pleasant as is practicable, for it has been found by experience that women offenders respond to small amenities in their environment. In such an institution a certain amount of psychological treatment, which would be wholly ineffective in the atmosphere of a present-day prison, could be carried out with success for those offenders who were in need of it (172).

While these writers demanded a greater input from medical psychology in specially constructed prisons, it is important to note that women prisoners in the 1920s and 1930s still experienced a regime that was orientated towards them as individuals by emphasising a rehabilitation specifically designed to socialise them into patterns of work, and a life-style of the traditionally accepted female kind. In the late 1920s and 1930s, young, physically fit women in Holloway were employed in housework or gardening. Additionally, they had instructions in cookery and table service for two hours each week. There were classes in elementary education and in embroidery, current affairs and "house-wifery". Finally, they received instructions in needlework and dressmaking (173). Similar programmes existed for the adult women who were clas-



sified into various groups. Star Prisoners and Division 2 women who were physically fit were employed in the officers' quarters where they were taught housework and in the officers' mess where they were instructed in cookery, table service and kitchen work. Others were employed in needlework and plain dressmaking. For those sentenced to penal servitude, the labour was much the same. The physically fit were taught laundry work. The remainder were employed in ordinary prison washing or were taught kitchenmaids' work or plain cookery. As the Prison Commissioners commented, "many of these women are capable of filling posts such as kitchenmaids, scullery maids, or as vegetable cooks in hotels, restaurants or hospitals" (174). All women serving three months or over attended evening classes where they were taught embroidery, knitting, beadwork, toymaking, leatherwork, weaving, rugmaking, stoolmaking, basketwork and pottery. Those who did not attend evening classes had to accomplish twelve feet of sewing per night. Any woman whose work was regarded as unsatisfactory was cautioned by the trade instructor and was then reported to the governor if her labour showed no sign of improvement.

The kind of education which the female prisoner received was equally restrictive. At its annual conference in 1928, the National Association of Prison Visitors to Women complained about the classes in current events and citizenship and about statements made by voluntary teachers. As the Association commented:

The young prisoners especially spoke of the remarks of a teacher regarding coloured men: that girls

'should not object to being spoken to by coloured men' and that 'they should not mind marrying black men.'

However well intentioned the teacher may be, such statements show how utterly unsuited she is to speak to girls of this class, understanding nothing of their outlook and mentality and not realising that one of our greatest difficulties is the association of girls with men of colour (175).

Consequently, the Association recommended that classes on current events and citizenship should cease and that the news given each week to the prisoners by Prison Visitors should be regarded as sufficient. Furthermore, the Association thought it desirable that there should be classes on infant welfare, mothercraft and first aid, remarking that "considering the class of women at Holloway and that so many are mothers it is unfortunate that certain classes are on subjects of such an unpractical nature".

Other Prison Visitors strongly agreed that controversial subjects should not be introduced and criticised the importation of newspapers into the prisons to be read to the women. Though some Visitors felt that a certain amount of teaching on subjects such as Shakespeare was desirable, they all maintained that a larger place should be given to more "practical" subjects. It was also noted in the Prison Commissioners Report for 1929 that the daily proportion of women under treatment in prison hospitals was far higher than for men. Whereas one in eleven of the men was under treatment at any given time, almost one in three of the women was receiving treatment. According to Miss E.H. Kelly, a member of a Committee on Women's Prisons these figures were "startling, but apparently, there was nothing unusual from the prison point of view." She indicated that none

of the privileges awarded to men at Wakefield or Wormwood Scrubs had been extended to women. Such privileges included the payment of small wages, honour parties, special arrangements for visitors, longer hours out of cells and dining in association. It was also pointed out that the bed sheets in the women's prisons were changed only once every month (176).

The issue of the psychological treatment of women offenders was given further legitimacy by the publication of a Medical Research Council Report in 1933. Authored by the psychoanalyst Grace Pailthorpe, and focussing on delinquent women and girls, it had, according to Dobash et al "a profound impact on official thinking about women prisoners". Pailthorpe studied 223 women and girls detained in prisons and preventive rescue homes and concluded:

deficient biological development was revealed in underdeveloped immoral sentiments and various psychopathologies. [They were] 'sick persons' who .... should be regarded in the same light as people suffering from various contagious fevers (177).

She argued for segregation and psychological correction:

Her ideal approach would involve extended 'Psycho-analysis [as] .... the only radical cure for all psychological maladjustments'. For women described as passive mental defectives, prone to promiscuity resulting in pregnancy, permanent segregation could be useful but sterilization would be best since it would allow them some freedom (178).

For Dobash et al, Pailthorpe's work was important in that she can be linked with the early bio-psychologists such as Maudsley, Tredgold and Cyril Burt who saw women's innate biology and

sexuality as the source and cause of crime:

For some this was because women were overtly masculine, for others because they were compelled by periodicity. Criminal women were seen as outside the boundaries of the ideal, chaste, cloistered, Victorian woman and in need of unique, individualised treatment (179).

Other commentators made similar points. Calvert and Calvert cited Pailthorpe's study and in particular her view that 56% of all the women she examined, excluding mental defectives, needed psychological treatment (180). In 1937, Dr C.P. Blacker, the General Secretary of the Eugenics Society edited a collection of readings with the title A Social Problem Group? The social problem group fell into two categories: the "medico-psychological" and the "sociological" with an intermediate group occupying an uncertain position between the two. The insane, mental defectives and epileptics fell into the first group, pauperism and slum dwelling into the second while "recidivism, unemployability, inebriety and prostitution are conditions more or less intermediate between the medico-psychological and the sociological" (181). W.H. De. B. Hubert, the psychotherapist at Wormwood Scrubs contributed a paper on "Recidivism and the Social Problem Group". He raised a number of questions about women prisoners and indirectly about women in general. For women alcoholics, Hubert enlisted the views of the governor of Birmingham who saw them as "a pathetic and hopeless collection of human wreckage. They come and go with unfailing regularity and are assisted again and again without making any effort to help themselves. It is doubtful if they are capable of effort". This kind of conceptualisation allowed Hubert to offer a more general

view of deviance which was not restricted to a simple question of heredity. In this sense, "environmental influences may act upon an hereditary weakness to produce anti-social behaviour, or, under different circumstances, forms of behaviour which will create other social problems". He made a number of points in conclusion:

Investigations show that a high percentage of criminals come from broken homes - suggesting a close relationship between other social problems and the beginnings of crime ..... Modern authors, in contrast, to older writers who stressed a specific inheritance, hold that while the hereditary factor is of great importance this is merely a tendency which may show itself also in other asocial forms of behaviour as well as in actual crime. Research on criminal twins conclusively shows the importance of hereditary factors. The importance of more carefully controlled work is evident. Attention might be profitably directed towards particular types of recidivists rather than to the group as a whole (182).

By the 1940s and 1950s individual psychology and the family environment were the rocks on which professional and state intervention into the lives of criminal women was built. For individual women, they were also the rocks on which their chances of a fulfilling and free life-style were dashed and broken.

Women Prisoners in the Post-War World: A Thorough Grounding in Mothercraft.

In February 1947 questions were raised in Parliament about conditions in Holloway. Women prisoners in the gaol were not

allowed privileges in any circumstances for the first 3 months of a sentence. After 4.30p.m. they had nothing to eat until 6.30 the following morning and were locked up early because of staff shortages. These problems continued until August 1949 when it was reported that a senior Home Office official was to visit the prison "as a result of recent disturbances among girl and women prisoners there and consequent complaints by the prison staff". This visit followed a meeting held by the Holloway officers who complained about general indiscipline amongst the prisoners. They asked that, "Borstal girls and girls who had their licences revoked should be transferred from the prison" (183).

Commentators at the time recognized the different responses of women to the prison environment. Winifred Elkin talked of women prisoners being "highly emotional and unstable" which was intensified by the monotony and dreariness of life inside. She commented that "hysterical attacks of 'breaking up', when a woman goes berserk and smashes everything within reach, are a recognized phenomenon of the women's prisons" (184). Joan Henry's account of life in Holloway and York at this time described a similar story of revolt:

Women constantly have nerve storms when they will smash up everything in their cells, from which they will then be removed to the padded cells. This either quiets them down or sends them completely off their heads. It is not necessary to call in anyone from outside to certify a prisoner, as there are at least three doctors on the premises. It is an everyday occurrence in the hospital to inquire after someone only to find she has gone to Broadmoor (185).

For the women the prison regime, and the philosophy upon which it was based, was specifically designed to challenge deviance by resurrecting and re-asserting their maternal and domestic instincts. The Prison Commissioners outlined how they saw these regimes in their first post-war report. The direction of the women's "training" was towards making them better citizens in the modern world and while some industrial training would be provided for younger women, the Commissioners anticipated:

the greater part of the work will be domestic, though directed towards training better housewives rather than better housemaids. With the "cottage home" as the background, every aspect of the domestic work, whether in shops or the service of the prison, should be made to serve one idea - that of instilling into the women the ideals of a good home and how they may be best achieved (186).

Furthermore, the appearance of the women was to be reconstituted.

They did not think it helpful that a woman's appearance was

"a source ..... not of pride but of humiliation". Consequently, they saw no objection to "the use of cosmetics if the administrative difficulties can be overcome" (187). The following year the Commissioners reported that when they left the prisons and Borstals, young women, "girls" in the words of the Report, went into factory work, the catering trade, hospitals, clerical work and the Women's Services (188).

The Report for 1948 painted a similar picture. Domestic work in hospitals, nursing homes, working on farms, factory work and work in the textile industry absorbed the main bulk of those discharged from Borstals for young women. A large number of them married within a year or two of their release which brought

more problems. These problems were "many and varied, particularly when the husband is of different nationality or race" (189).

Women classified as neglectful mothers were a particular cause for concern. In 1945, the Women's Group on Public Welfare, together with the National Council of Social Service, appointed a Committee to study and report on "the neglected child and his family" (190). The Commissioners arranged for the study to be conducted at Holloway which would cover the years 1947-9 and concentrate on women sentenced for child neglect. In June 1949 the governor of Holloway outlined some of the main findings of the study and concluded that "poor intelligence is an important factor in neglect" (191). This "lack of intelligence" directly contributed to the fact that these women could not improve their already poor home conditions. Finally, irresponsibility on the part of the women led them to be either ignorant of, or ignore lessons in, child-care management. As the governor concluded:

Their irresponsibility is a state in which responsibility is not realised, and the poor early environment of many of them may be a cause of this. It is not the kind of irresponsibility which says "If I don't do my job, I can go to the cinema" but a state in which it is not realised that there is a job to do. The domestic standards of some of these women were very low, and they regarded an appalling state of affairs as adequate. Others of them knew that things were not right, but they did not know whether it mattered much or not, and in any case did not know what to do about it. May we stress the usefulness of giving these mothers one instruction. When of good will and anxious to do better they must be told the same thing over and over again. They must be constantly helped and encouraged to do that one thing. When they have got that perfect they can be instructed in another thing and so on until an adequate domestic standard is reached (192).



By February 1952, acting on conclusions drawn from the study at Holloway the Commissioners had introduced a special training scheme for women which was based in Birmingham prison. Twelve women, who were serving sentences of three months or over, were transferred from different parts of the country to take courses in elementary housewifery and mothercraft. The course was started after the study at Holloway concluded that women who were sentenced to terms of imprisonment suffered from "low intelligence, poor social environment in early years and irresponsibility resulting in inability to cope with ordinary domestic life" (193).

The Prison Commissioners reiterated this perspective by drawing on case-histories compiled by the chaplain of the prison which concluded that although the home conditions that led to the charges were "usually appalling, this was often the result not of poverty but of wasteful and unintelligent spending, bad housing which readily induces slovenly habits, unhappy marital relationships or the low mentality and poor physique of the mothers" (194).

These explanations formed the basis of the state's response to the women, and were legitimated by the pronouncements of professional experts such as the doctors. In the Commissioners' Report for 1952, one unnamed doctor pointed out that brutality and sadist were the wrong labels to apply to the women. Rather those "who have been in the service for any length of time were fully aware that the salient features of such cases were the mental subnormality and general unfitness of such people to be parents" (195).

The syllabus for the course, aimed to remove the problem by striking at its moral root. This centred on the women's inability to cope with the domestic environment. Each weekday from 9.30 to 3.45 the women worked in the Education Department of the prison learning housewifery, cookery and laundrywork. Additionally, the house in which the "trainees" lived had to be cleaned throughout the day. On Monday and Wednesday evenings they were given a 1½ hour lecture, supported by visual aids, on a range of topics including the bathing of a baby, the physical needs of the child, ante-natal care and "the man's place in the home - given by a male lecturer" (196). Other talks and demonstrations focussed on the mental and emotional development of the child, how to care for the sick, and on Thursday evenings "one lecture in each course by an officer from the Gas Offices - use of cooking appliances" (197).

The chaplain was hesitant to make what he termed "dogmatic generalisations" from this sample about the typical woman charged with child neglect. Nevertheless, he did provide a picture of what she was like: in her early 30s, married, but on an uneasy footing with her husband who probably had similar personality defects as her own:

She is of low - average intelligence and may even be feeble-minded. Her personal and social inadequacy is evident when assessed apart from the offence and is partly the outcome of a childish level of effective integration and of the stifling effect of her environment. She has been accustomed for many years to live a hand-to-mouth existence, first in her own home and then after her marriage to a man earning a comparatively low wage (198).

Similar assessments were made by other prison staff, including the doctors. In 1954 one reported to the Commissioners that 62 prisoners had attended the special mothercraft classes during the year. Of this number, 38 had been charged with child neglect. After being interviewed, the prisoners were assessed:

Generally speaking the mothers were of low intelligence and although they maintained that they had learned a great deal from the course, it is doubtful if those of low intellect had the capacity to carry their teachings into practice after release from custody. The after-care of these prisoners is extremely important in order to observe the results of the course (199).

After-care at Birmingham consisted of a network of voluntary agencies such as the W.V.S. Prison and Probation Service. From April 1953, Local Authorities became involved through the health visitors scheme. As the chaplain explained:

As soon as possible after her return home a representative of the W.V.S. calls, usually a lady living in the same locality and the aim of this lady is to help with her advice and to guide the mother through the difficult weeks that face her in having to return to a home as sordid, dirty and ill-equipped as it was when she left it. It will be realised that much of the good done by the training will be quickly undone if the mother loses her spirits immediately on the sight of what is often squalor (200).

The scheme lasted for eight weeks. The prison provided equipment which it was felt the women were likely to have in their own homes. It was meant to give them "a thorough grounding in mothercraft". The practical work done during the day was supplemented in the evening by instructors from the health, education and welfare departments of Birmingham City Council. The Howard

League for Penal Reform welcomed the scheme as a "progressive measure" but while giving "full marks" to the Commissioners for their "enlightened attitude" Hugh Klare, the League's Secretary, felt "it would be much better if neglectful mothers could be trained in buildings entirely free from the prison atmosphere" (201).

Such schemes were not unique to Birmingham. They plugged into the general orientation in women's prisons. Lionel Fox, the Chair of the Prison Commission described the operation of regimes in women's prisons in the early 1950s. In his book The English Prison and Borstal Systems, published in 1952, he discussed the regime at Askham Grange, the first training prison for women which had opened in 1947. The prison housed 60 women, with the day's work being based on a "thorough training" in various aspects of home-making, cookery, housewifery, needle-work, gardening and laundry work. Fox emphasised:

this is training ..... the conditions of the house make it possible, in a way that is not possible in an ordinary prison, to relate the training to the needs of ordinary life: the women become really competent cooks and needlewomen, learn how to do home washing and finally go through a course of Cookery and Home Management prescribed by the County Council who examine them at the end (202).

In the evening there were classes in embroidery, dressmaking, toymaking and leatherwork. In addition, there were lectures on child welfare, home nursing, first aid and personal hygiene, with classes in English and other subjects. Fox concluded that the whole programme was of "real value to women who will for the most part return to their homes or be called on to make homes" (203).

The course continued until the end of 1961 when domestic training was transferred to Holloway. Here the course followed much of the same pattern but its character had been "improved by arranging for some of the officers in charge of the women to take part in the instruction. This helps to integrate discipline and domestic training and increases the field of the officer's interest in her women" (204). Domestic training was to be extended to the new prison at Styal which the Commissioners hoped to open in the autumn of 1962. (It was eventually opened in January 1963). It was to be based on "separate houses" containing between 14 and 22 women where they "will lead a more normal life than they can in a large institution" (205). This normal life consisted of cooking, cleaning and doing personal laundry on a house basis. It was hoped that "the woman's house will come to be the centre of her life and training while she is at Styal" (206).

These programmes were themselves supported by state servants. From her 42 years experience in the prisons Mary Size, the first governor of Askham Grange, was quite clear about the cause of women's crime and what role rehabilitation and reform should play in the direction of their lives:

Ignorance, inefficiency, selfishness, jealousy, bad housing, bad family relationships, and lack of Christian teaching, together with a certain degree of mental abnormality, are responsible for much crime amongst women. We made every effort to help them to regularize their lives and to teach them how to live decently. They were taught the value of team work and efficiency, self-discipline and respect for the rights of others, their own importance in the community

as wives and mothers and the responsibilities which this entails (207).

The Prison Commissioners were more succinct but no less directive in their views about the education of the prisoners. Educational programmes for women and girls they noted in 1960 "are naturally more concerned with the home and the family" (208). Importantly, it was not only state servants who were propounding such views. Mark Benney's Gaol Delivery, published in 1948, was an account of the prison system during the war years. It was based on the testimonies contained in a 100 replies to questionnaires prepared by the Howard League for Penal Reform. Benney outlined the problems regarding women prisoners in the following terms:

Women offenders .... present problems peculiar to their sex and status. They have babies for instance and often their best chances of rehabilitation lie in marriage. Adequate training in home management is of paramount importance and this is best provided for in the cottage home type of institution such as has been developed very successfully in other countries (209).

The women were also still subjected to surveillance and regimentation by those in a different and higher class location. At Aylesbury during the Second World War, Lady Amptill was the Chair of the Board of Visitors. The Viscountess Courtoun was a member of the Board, a local magistrate and Head of the Women's Voluntary Service. The Mayoress of Aylesbury, Olive Paterson was also a Board Member and Chief Magistrate (210). A similar picture emerges for Askham Grange. In 1947 "the members of that Board were chosen mainly from professional

and business men and women in the York area who had done outstanding work in their respective professions" (211). The voluntary visitors were "ladies who had previous experience of social work in some form or other" while Anne Franklin, the handicraft teacher attended the prison three evenings a week and taught a two hour class. Under her instruction "the women learned to make toys, gloves, lampshades, various kinds of rugs, weaving, cane work and other crafts" (212). In July 1957 Joanna Kelley, the governor of Askham Grange continued the same theme. Writing in the Journal of the Medical Women's Federation she described how the prison resembled "a very strict boarding school" (213). During the day domestic subjects such as laundry work, cookery, sewing, housewifery and gardening were taught. Evening classes covered subjects such as current events, drama, dressmaking, home decorating and embroidery. The school analogy was continued both in terms of the establishment of a well defined routine and to the relationship between officers and prisoners:

The women tend to respond to this Boarding School system by behaving rather like school girls, even if on the whole quite sensible well-behaved ones. Small events and sayings assume big proportions: there is childish excitement over treats, such as concerts, films, an extra cigarette each, outings. Like children, their voices are apt to rise. They are often overwhelmingly downcast by rebukes, their sense of proportion seems out of gear. They become absorbed in the day to day events of the establishment, which is like an isolated world, and any other life becomes to them as far away as "when I'm grown up" is to a child. It is as if their measurement of time had changed. One thing that is not adolescent is the amount of gossip, often ill-natured, that goes on. It is of course at some times worse than others, but is always a cause of unhappiness. Although the women like and respect the officers, there is a "we" and "they" attitude to them which is more like that of children and grown-ups than two groups

of adults. I think this is shared by the staff to some extent (214).

Kelley was to become governor of Holloway in 1959, a post she held until 1966.

From the point of view of women prisoners, the regime was made up of a number of elements, each of which imposed itself into their lives in an attempt to discipline and regulate their patterns of behaviour. Their accounts testify to the often appalling physical conditions as well as the philosophical nature of the regime orientated to winning hearts and changing minds. As early as 1943 the Prison Medical Reform Council was publishing details of life inside Holloway. On reception women were quickly examined by the prison doctor, had a lukewarm bath and then were given prison clothes which consisted of a cotton vest, knickers, a cotton frock, black woollen stockings and shoes. This reception bundle also contained two sheets, a pillowslip, nightdress, towel, handkerchief, face cloth and tooth brush. After reception they were taken to the cells:

In my cell, I found a tiny piece of soap, not more than 1 inch by 1 inch by  $\frac{1}{4}$  inch in size (which had to last me for all purposes for over a week) and a very slimy rag, both left by the previous occupant. .... Unfortunately, the rag and soap were not the only things left behind by my predecessor. On the shelf were dried faeces, under the mattress were some grimy, hair-curling rags and on the floor, furniture and all the utensils was a layer of grease and dirt (215).

It was not only the physical conditions that made life inside difficult for the confined. The women complained about prison



labour. Many were employed as cleaners on the landings and had to clean the lavatories. They were "always in a filthy condition and usually three out of four were stopped up" (216). These cleaning jobs meant that some of the women had to work in the recesses cleaning the pails containing soiled sanitary towels:

Every morning these were taken down for the contents to be burned. There was no lid on any of the pails I had to empty; nor were they ever disinfected ..... Much of the food was unsavoury. The greens were always dirty but I had to eat them, I was so hungry (217).

Women also complained that when they went to seek medical help for any ailments they were regarded as "malingerers" and were either ignored or had to wait for some time before they were treated. For pregnant women the situation was even more severe. They had the ordinary prison diet until they were six months pregnant and then were given two extra slices of bread and a half a pint of milk each day. They spent 23 hours either sitting or lying down and were locked up in their cells alone each night up to the time the baby was due. This could have serious consequences:

The cell emergency bell often went unheeded especially during the night. One could keep ringing the bell for over an hour without having attention paid to it. On one occasion before I went to hospital the cries of one of the girls were pitiful. We could hear her calling for help and getting more exhausted. The whole landing was awake in the finish and several other prisoners were ringing their bells and calling to draw attention to her. I heard from several prisoners in the morning that when help came it was found that her baby had been born in the cell (218).

Joan Henry's account of her experience in Holloway in the early 1950s covers similar ground. She was particularly critical of the medical treatment. Many of the women in her experience *never had a normal period during their imprisonment "or perhaps only twice a year"*. She felt this was due both to the shock of imprisonment and "possibly to a starchy diet and little exercise. The medical officers do not seem to worry about it at all" (219). She described the interaction between herself and the hospital staff:

That first morning I cleaned the cell with my handkerchief, and that was about all I could do. Hours passed, and eventually a doctor, accompanied by one of the hospital sisters, visited me on her morning rounds. I had never seen her before.

"Are you all right?"

I was to become accustomed to this phrase after a few weeks in the hospital. It was used in varying tones by the head sister, doctor, and matron on their separate rounds every single morning.

The correct replies were:

"Yes, thank you, Sister."

"Yes, thank you, Doctor."

"Yes, thank you, Madam,"

even though you might be dying on your feet. The questioner looked as surprised as you felt if you made any different answer; it becomes so automatic that prisoners have been known to say, "Yes, thank you" before the questioner has said "Are you all right?" thus throwing the whole conversation out of gear. Knowing nothing of these conventions, I muttered something about my foot, which was duly examined without comment as before.

Later matron appeared on her rounds with the sister on duty. It was freezing cold, and a sixty-mile-an-hour gale seemed to be blowing through the cell; indeed matron had to hold onto her cap while she asked, "Are you all right?" and her eyes swivelled round the room and under the bed. Then: "Rather stuffy in here," she remarked. "Open the window a little bit wider."

With this she swept out, leaving me with thoughts of Scott at the Antarctic (220).

Officer gave his account of the work done by prison hospital staff and how this work, particularly with women who had verminous diseases, was not fully recognized. Additionally there were a "number of evil-smelling, filthy bodies who nauseated the staff in reception and had to be supervised by the sisters in washing and general cleanliness" (221).

It is important to recognize that these attitudes and institutional programmes could be underpinned either by the threat of or the use of violence against confined women. The lobotomy is a good example of this. Since 1941, the majority of the 15,000 lobotomies carried out in England have been performed on women. One writer expressed the view that "psychosurgeons consider that the operation is potentially more effective with women because it is easier for them to assume or resume the role of a housewife" (222). In 1947 alone, it was reported by the UK Board of Control that "out of 1,000 [psychosurgical] patients 65% per cent of leucotomy patients .... were female" (223). In Broadmoor techniques such as electro-convulsive therapy were also common in the 1940s and 1950s. Patients would be given it "raw" which meant having no muscle relaxant or anaesthetic. There was a moment of "convulsive pain" when the shock was propelled to the brain:

The electricity coursing through the body lifts the patient a few inches into the air and their hair does, literally, stand on end. Sometimes 'raw' E.C.T. led to back injuries and, very occasionally to death because of breaking the spine(224).

Researching Women: Psychiatrizing Behaviour.

As in the 1940s, the criminality of women in the 1950s was a special object of study. Female prisoners in both Borstal and adult institutions provided a focus for psychologists and medical personnel interested in what appeared to be the small number of women who could not adjust to their allotted domestic role in society. Hence, their criminality. Such women had to be re-adjusted to fit that role. The themes of individual and constitutional pathology, influenced by the wider familial environment, was the dominant explanatory framework within which the deviant behaviour of young women, in particular, was understood. Dr Phylis Epps, who worked in a Borstal and subsequently at the Institute of Social Medicine in Oxford, wrote a number of papers in the early 1950s which elided both themes. Between April 1948 and August 1950, she surveyed 330 young women committed to Borstals in England, Wales and Northern Ireland. While admitting the work was carried out during her "very inadequate spare time" (225), publishing in the British Journal of Delinquency provided an important academic forum for her ideas. Two hundred and seventy five of the women were kept under daily observation while 25 were seen only once for "a brief interview and intelligence testing". Epps outlined a host of factors she considered to be important including family history, illegitimacy, psychosis, menstrual function, school record, emotional instability and mental state. In the last two categories she reinforced many of the prevailing ideas about women's criminality, first that they were less intelligent than the average non-delinquent and

second the emotional instability of young women created disciplinary problems:

Since the days of Lombroso immaturity has been noted by numerous observers ..... to be a common characteristic of criminals. It was particularly noticeable in this as in the prostitute group .... (226).

She concluded that interventions should work at a number of levels. Citing Bowlby, she called for social work intervention with problem families "with a view to preventive treatment of other, probably younger members of the family". The women needed:

careful individual investigation such as would be available at a well-equipped Allocation Centre in order that the correct factors in training and treatment may be provided. The danger of contamination among females is as great as, if not greater, than among males of this age group. It can be reduced by careful allocation to the appropriate establishment, which preferably should be small i.e. for 50 or under (227).

In 1952 Epps, in collaboration with P.W. Parnell, the physician in charge of the student health service in Oxford, published another paper. They compared the physique and temperament of women delinquents with undergraduates. This time the forum was the British Journal of Medical Psychology:

In studying two groups of young women, one delinquent and the other student, corresponding differences in physique and temperament were found. The delinquents were shorter and heavier in build, more muscular and fat; their temperaments showed a predominance of somatotonia and viscerotonia over cerebrotonia, broadly confirming Sheldon's work ..... Old notions, in particular the one advanced by Lombroso, of a constitution disposed to crime, may be investigated with advantage by modern tools for the assessment of physi-

que and personality. Further work is needed before definite conclusions are drawn, but other delinquent groups, such as Borstal failures and recidivists, invite study, for comparison both with each other as well as with non-delinquent groups. The factor of physical constitution cannot, of course, explain why among individuals of a given physique, only a certain proportion become delinquent, but the confirmation that a strong constitutional factor exists provides one answer to the question why some individuals are susceptible to adverse environmental influences and become delinquent while their fellows avoid this fate (228).

In 1954, Epps followed up the original study of the 300 Borstal women by analysing data on 100 of them for the British Journal of Delinquency. While larceny remained the commonest offence for which they were sentenced, "continued social maladjustment" was the major problem. She called for more work to be done on prediction tables as the Gluecks had done in the USA. In addition, careful classification was needed to prevent the sexually promiscuous from "unduly influencing the sexually inexperienced". Finally:

External and internal factors in social maladjustment are much interlinked, but those girls who have to return to unsatisfactory homes need considerable help from a social worker, whose efforts need to be directed both towards the girl and the parents, or parent substitutes. Much work is also demanded from the social workers concerned with the care of girls released with their babies. A follow-up study to show the number of girls who eventually separate from their children might suggest that, in the light of work done by Bowlby and others on the effects of separation on personality development in the child, more attention could be directed to the least unfavourable time of separation (229).

What is striking about these and other studies on women prisoners at this time, is the emphasis on constitutional factors in women's criminality. As with men, the local home environment was regarded

as important. However, unlike men, there was a stronger emphasis laid on the importance of biological and psychological variables in their deviance. Once more, medical personnel were at the forefront of these investigations.

In December 1961 Katharina Dalton, a GP and Honorary Clinical Assistant in the Department of Psychological Medicine at University College Hospital in London described how, over a six month period, she interviewed all newly convicted women prisoners below the age of 55 on the first week-day of their sentence. She asked the women about their age, duration of menstruation, length of cycle, date of last menstruation "and whether they observed any symptoms before or during menstruation. A similar interview was arranged for all prisoners who had been reported to the governor for bad behaviour while serving their sentence". She concluded there was a:

marked similarity of the effect of menstruation on naughty schoolgirls, newly convicted women and disorderly prisoners .... The analysis shows that there is a highly significant relationship between menstruation and crime. This could mean that hormonal changes cause women to commit crime during menstruation and the premenstruum and/or that women are more likely to be detected in their criminal acts during this time (230).

In November 1962, Moya Woodside, a psychiatric social worker at Holloway published the results of her survey in the prison. She studied the records of 139 women and interviewed 137 (two had been sent to an open prison before she could see them). Woodside outlined the psychiatric history of the women and adopted in her words "a rough and ready criteria of instability." It contained

categories derived from the work of the P.M.O. at Wakefield. These included "subnormal", "instability", "positive mental history", "neurotic" and "psychopathic". In addition she looked for "social disorganization" in the women's lives. This revolved around "irregular unions" with men and "illegitimate maternities":

39 women, or a quarter of the sample, were living with men not their legal husbands. 14 of these 39 had been classified as unstable, likewise 13 of the 22 who were divorced or separated. 6 of the cohabitantes were coloured men, as were 2 of the legal husbands (except for 2 half-castes, all the women in the sample were white). 36 of the women were known to have male criminal associates; several of the husbands were serving prison sentences. A further index of social disorganisation was the number of illegitimate maternities. 39 women had 65 illegitimate children, 24 children were offspring of irregular unions existing at time of sentence. 10 women were pregnant out-of-wedlock at time of sentence (5 single, 5 cohabiting). 19 of these mothers had a positive psychiatric history (27 illegitimate children, 5 pregnant out-of-wedlock on admission)(231).

She argued that 58 women had a positive history of psychiatric disorder. Evidence of instability was found in 10 others. Finally, "social disorganisation" as manifested in irregular unions and illegitimacy, was "frequently concomitant with delinquency" (232).

Woodside's project was one of a number conducted at this time. Each had a strong medical and psychiatric input. The list of projects undertaken in women's prisons in 1961 indicates the kind of work which was being funded: the psychiatric social worker at Holloway published a paper on alcoholics, carried out research on abortionists in the prison and "made a survey to



discover which of the women might be suitable for psychiatric treatment"; the staff led by a senior psychologist conducted an exercise in Borstal allocation; the M.O. and one of the chief officers investigated the case histories of women sentenced to preventive detention. At Birmingham the psychologist examined the domestic training course "investigating the intelligence, case-histories etc. of the women undergoing it and assessing the results" (233).

Prison regimes directly reflected the drive to normalisation inherent in the research. Group counselling provides a good example of this process. It was based on the idea that female prisoners could work in a community with other prisoners. Crucially, it was a community based around the principles of motherhood and domesticity with the woman as the "key site of intervention" (234).

In 1963 the Prison Commissioners indicated that the group counselling class in Holloway had "extended far beyond its original conception" which was to ease tensions between prisoners and staff. It was now being used as a "means of communication" between not only prisoners and staff but also between prisoners and their husbands. Counselling groups were run by married women officers and their husbands. Prison managers sought to make womanhood the common link between prisoners and staff, a link that was to transcend the respective statuses of gaoler and gaoled. During the sessions:

frustrations are aired, difficulties are discussed and problems are shown to be something which all women may have and which all can share in attempting

to solve; they are not isolated phenomena to be looked at in horror and then thrust away as soon as possible. Group methods are also used for social therapy. The reasons for social failure are being explored in the hope that the women concerned may come to see their personalities and circumstances objectively, and to help each other avoid the same pitfalls in the future (235).

The governor of Holloway at this time was Joanna Kelley. In 1967 she published her autobiography, When the Gates Shut. Kelley provides an illuminating insight into the nature of the psychiatric regime in the prison in the first half of the 1960s. The psychiatrist was responsible for diagnostic groups such as the Husband and Wife Group and the Young People's Group. In 1964 they were fused and became the Family Group. Therapeutic sessions were designed to strike at the causes of crime. Kelley had her own views on this:

A frequent cause of delinquency is inefficiency. Surprisingly, many women, although they have large families to cater for, are unable to cook and have little idea of marketing wisely or planning a budget. They may live in accommodation with no facilities for cooking other than a gas ring. One such woman and her family lived on bread and jam, fish and chips from the shop around the corner, tea, which she could make, and food out of tins: an extravagant way to live. She was ecstatic when taught in prison how to cook and to market (236).

When a husband fell ill, became unemployed, deserted the family or died then "at such a time the old-fashioned virtues of thrift, inventiveness and self-denial would be of value" (237). In the Borstal wing there were often "stories of rape, incest or cruelty." Again, it was the prisoners who had to be changed by a regime which would "help them to adjust themselves to their incapacities so as to be able to live as normally as possible" (238).

A network of psychiatric personnel reinforced the direction of the regime. There were four doctors for the 300 women in the prison. They were supported by a psychologist, a psychiatric social worker, two part-time psychotherapists,

a part-time physiotherapist, chiropodist, dentist, gynaecologist, venereologist, and optician. Additionally, the hospital was staffed by:

about forty sisters and nurses: two of these are male hospital officers whose presence has made a great deal of difference to the discipline of the hospital; without apparent effort they are able to quieten and control the most difficult patients (239).

In spite of the image of psychotherapeutic togetherness, the reality was often more fractured and brittle. As in the 1940s psychotherapy and psychiatric intervention was resisted both by the prisoners and prison officers. Kelley points to continual conflict in the Borstal wing where prisoners were aggressive towards the staff and other inmates. Furniture was broken and windows smashed. There was a "phase of inward aggression ..... there was a great deal of tatooing, self-mutilation and swallowing of needles" (240). Many of the older officers did not wish to become social workers nor did they support open wings or group counselling. For them, punishment should be the basis of imprisonment. They were "sceptical of the value of rehabilitative work ....." (241).

Overall, however, these contradictions and conflicts were not regarded by Kelley as the major problem. It was the women who were the focus of attention. In her view "women who break the

law and are sentenced are likely to be more disturbed than men who do so" (242). Changing the behaviour of some of the prisoners and dealing with the disturbed rejection of their outside social role meant subjecting them to a domestic training course similar to the one at Birmingham described above. Between 1962 and 1964, 211 women participated in the course, 118 of whom had been sentenced for child neglect. The other participants were those "with large families who are thought to be in need of such training" (243). Kelley indicated how she gauged the success of the course in adjusting the women. She described the behaviour of two women who were allowed to leave the prison for outside work:

There had been the further difficulty at Holloway that women with homes in London tried to visit them and to do too much in their spare time. Two women, for example, started leaving the prison at half past six in the morning, much earlier than was necessary for them to get to work in time. One it was discovered, was making her husband's breakfast and trying to get him off to work, the other was scrubbing her front step and cleaning up. This was heartening in a way, for it showed that their minds were working along acceptable lines; the difficulty was that they became so bitter and restive at having to come back to prison at night (244).

She generalised this point to the overall work which the women were required to perform:

We have seen that many women come to prison just because they are inadequate and inefficient; they cannot get or keep a job or they cannot run their homes and this leads to trouble. So an important part of any treatment of such women in prison ought to be training them to work. The ability to apply oneself to work and to tackling one's problems is to some extent simply a matter of training and habit. A person who is accustomed to

working regularly, who is able and efficient in other respects, is less likely to fall foul of the law. These qualities are the prerequisite of the condition of 'normality', for which so many law-breakers, however aberrant their records, so often yearn (245).

Normalisation through psychiatric counselling was supported by a process of infantilisation. The women were treated like children. The relationship between the officers and prisoners was like that of a child to its nurse, "nanny is kind and forgiving, but firm; she always knows what is best for her charges" (246). Recidivists were "immature, having the egotism of small children":

and some of the small child's jealousy when too much attention is paid to someone else ..... Their desires and emotions are of paramount importance to them and because they have little self-control, they give way to the impulse of the moment without hesitation ..... They have become inadequate to meet the normal demands of life and to shape their lives within the social framework (247).

This process was described by other state servants. Between November 1961 and October 1962, A.M. Morgan who had worked at Holloway for 20 years, conducted a survey of women sentenced to Preventive Detention. In discussing recidivism amongst the prisoners Morgan drew an analogy with children:

A child who is learning to walk falls down continually at first. Should we not regard these lapses, in some cases, as the fall of a child till it has learnt where to place its feet? If a woman stays out of prison for a longer period each time between sentences - could it not be that eventually she will be able to walk without assistance (248).

The unsigned comments of a P.M.O., written in the Commissioners'

Report for 1961 also provided support for the normalising direction of the regime:

Fifty-one inmates attended the domestic science courses in the women's prison. Thirty of the 51 had been charged with child neglect. Thirty of the 51 were interviewed by the Psychologist, who found the majority of them to be below the average intelligence, nevertheless they all appeared to benefit from the course in regard to house-wifery and cooking as was demonstrated by them at the end of each course. The follow-up of those who attend the course continues to be encouraging; about 50 per cent appear to put their instruction to good effect on return to normal life (249).

Prisoners, once more, described a different reality. They discussed the regimes in terms of the enforcement of petty rules, constant surveillance and rigorous discipline. This discipline was often tied to cleaning the buildings. For Joan Henry in Holloway this meant "the floor of the ward had to be polished and bumpered till it shone like glass, and matron always examined the window ledges for any specks of dust" (250).

Jane Buxton and Margaret Turner's experience was similar.

Conditions in the prison were appalling, the discipline and regimentation severe, arm slashing frequent, medical services poor and medical staff abrupt. As Buxton pointed out she had "stopped looking for humanity or the normal consideration that civilised people give to those who are sick or in pain. As a prisoner I was apparently a second-class being and didn't deserve such sentiments" (251). Xenia Field's account about life in Holloway, published in 1963 also raised serious questions about medical services for women. It would be advantageous, to the prison medical services, she wrote, "if they were to become part of the National Health Service rather than to continue as an

independent service" (252). She described the hygiene in Holloway as "grim" while the prison hospital left "much to be desired by doctors, nurses and prisoners alike, but shortcomings are largely due to the unsuitability of the buildings" (253). Joanna Kelley conceded complaints were made about medical treatment but denied that prisoners were regarded automatically as malingerers. She felt "medical staff do have to exercise some caution in dealing with a body of women of whom a large proportion are warped and thwarted" (254). It appeared that less caution was used when it came to dispensing drugs. The prison employed two full-time dispensers who dispensed between "five and six thousand doses of medicine" each week to the 300 women. Kelley attributed this "incredible" situation not to the medicalisation of the womens' behaviour but to the fact that the women would hoard the drugs if they were issued as tablets. Consequently, "a woman needing to take a medicine four times daily must be dispensed twenty-eight separate doses every week" (255).

The criticisms of the P.M.S. did not alter the psychiatric thrust of the regime for women prisoners. As Field pointed out, while psychiatrists complained that women referred for treatment were not always suitable, nonetheless one member of the profession could state:

virtually all women prisoners need some help. The problem is to sort out the available treatment and to send the right prisoner to the right source of treatment. In a way simple befriending, human sympathy, raising morale, and planning for the future are just as much treatment, and just as necessary as, if not more so than, the highly esoteric techniques. Women prisoners are not necessarily

neurotics requiring psychotherapy, but many of them have badly organized and distorted personalities and need forward-looking management and support in life ..... (256).

As I shall indicate this psychiatric view was to reach its apotheosis with the announcement in December 1968 that a new prison at Holloway was to be built which would resemble a hospital. At the same time, the early to mid 1960s also saw the emergence of demands for tighter security and control in women's prisons. The female psychopath became an emerging folk-devil. Field herself had discussed psychopaths as those women who smashed up their cells and who were "not suitable to be among prisoners who are always an unstable community" (257). In 1964 the annual Prison Department report highlighted the problem of those who would not adhere to, or accept the prison regime. Such women were arcanelly described as "too afflicted or inadequate to take part in modern methods of training not only in open prisons, where those who fail ~~can~~ be returned to closed establishments, but also in the semi-secure prison at Styal" (258). It pointed to the changing "characteristics" of the prisoners:

A large proportion of the women are mentally unstable, alcoholic or drug addicted, or so inadequate in their daily lives that they need the skilled attention of welfare and social workers before they can be considered fit to take a responsible part in their own training and rehabilitation (259).

For those women who were "too afflicted" or "inadequate" to take part in such "modern methods of training", the Home Office had built a secure block at Styal. The block, however, was ineffec-



tual in dealing with the problem, so the prison managers considered a scheme for converting two of the houses into single room accommodation. One of the houses would contain women serving very long sentences while the other would "help the increasing number who prefer not to take part in community life" (260). A closed wing was also established in Holloway.

Once again, the justification for these developments was the behaviour of the women. Any rational or logical rejection of the prison regime was interpreted as a further sign of psychological imbalance to be probed, tested, quantified and controlled. For some P.M.O.s the emergence of the "female aggressive psychopath" was tied to wider, sociological factors. Writing in the in-house Prison Medical Journal in July 1965, John Knox the M.O. at Holloway, discussed some of these factors:

What makes it so difficult for us in the Prison Service is that one of the most marked public attitudes to life in this century has been a general desire to emancipate the individual citizen at the expense of society itself. With one accord it seems that we have strained every muscle to reduce discipline everywhere. Schools, young people factory workers, wives at work, easy divorce, condonation of murder and modifications to all kinds of institutions are to this end (261).

The next year Knox followed up this article with a contribution to a conference organized by the Medical Association for the Prevention of War. The theme was "the doctor and situations of tension" and it was held in July 1966. Knox told the participants "there may be no need for women's prisons in 30 years" and that "quite possibly there will be other ways of dealing with women offenders". He went on:

he wished people suffering from psychopathic illness could have a separate form of identification so that they could get the special treatment their condition deserved. He would like to see them 'coloured green or with two little horns on their heads' so that they could be distinguished from other offenders and treated with the particular care they required. 'The majority of our female psychopaths at Holloway look sweet and homely. They are pretty little girls. We try to treat them with special attention to bring down their tension and aggression but it is very difficult' (262).

The memorandum submitted by the Prison Medical Officers to the abandoned Royal Commission on the Penal System around the same time succinctly stated their collective position: "in view of the high numbers of mentally disturbed women offenders we also believe that there might be a case for a women's prison under medical direction" (263).

In 1967 the Home Office gave official blessing to this view by arguing in the annual Prison Department report:

Severe personality disorders and emotional disturbance are more prevalent among the women and girls than among the men and boys committed to custody. Whatever the factors contributing to the committal in custody of men and boys, it is clear that either the factors differ or they operate differently as regards women and girls (264).

It should be noted that these comments were being made in the context of a prison population whose crimes were overwhelmingly of a petty property nature and whose sentences were short. In 1963 88% of those imprisoned in England and Wales, without the option of a fine served sentences of 6 months or less. (In Scotland, the proportion was higher at 98%) (265). In her review of the position in 1965, Ann Smith provided a critical and alter-

native perspective to the official discourse of the period:

One conclusion can be drawn from the statistics - that imprisonment provides no solution to the problems of large numbers of anti-social women in the community today. It is, however, much more difficult to suggest satisfactory alternative methods of dealing with the alcoholic, the prostitute and the neglectful mother. No solution is likely to be found unless the State itself, and indeed the community as a whole, has the courage to experiment and bear the cost of such experiment both financially and through the consequences of those failures which almost inevitably will occur. The special problems of the delinquent woman have at all times been neglected - or glossed over by sentiment and unreliable male intuition (266).

This alternative view was not to prevail. By the late 1960s, the strand of security and control on the one hand and the psychiatrization of women's behaviour on the other were the dominant pivots in the regimes designed for women prisoners. On their own they did little to relieve the pain of imprisonment for the confined. Taken together, they propelled already damaged women still further into a pit of despair and individualised recrimination.

#### Women and the Contemporary System.

On 10th June 1969, a conference was held at Haverigg prison. In attendance were governors, deputy governors, administrative officers and the regional Medical Officer. Mr K.J. Neale of Prison Division 4 addressed the meeting. He pointed out that in December 1968 the Home Secretary had announced a comprehensive new policy for the treatment of women and girls. The

numbers in custody at that point fluctuated between 800 and 1,000 "and it was not anticipated that these figures would vary very much for the rest of the century" (267). He went on to announce that as women tended to be lodged further away from friends and relatives than men and because of the difficulty in maintaining the full range of psychiatric and medical services in more remote areas, the Home Office intended to divide the country into North and South. A full range of custodial establishments would be provided in each. While medical facilities would be made available on a broad basis it was Holloway with its "sophisticated treatment and specialised functions" which would have a national role to make good any deficiencies in the regions. The prison was to have a large staff with approximately one staff member to each prisoner, and two medical staff to one discipline officer. The essence of the establishment was to be that of a hospital:

Never before had there been a prison specifically designed for women and the new Holloway projected had necessitated much research. It would be orientated towards the provision of advanced sophisticated medical services and of the 500 places planned for women only 150 would be allotted normal prison accommodation .... The planning of the new establishment would afford the maximum operational flexibility so that whilst for therapeutic purposes work would be based on groups of inmates not exceeding 16, no difficulties would arise if it were found necessary at any time to provide treatment in any particular field for a sudden influx of patients (268).

This view was consolidated in July 1968 when the Prison Department established the Holloway Project Group which included representatives from the Prison Department and the Department of Health and

Social Security (269). Information had been gathered for the Group in 1967 by T.C.N. Gibbens of Maudsley Hospital. He conducted a medico-social survey of women received into the prison. This was passed to the Home Office Research Unit. As Dobash et al point out, Gibben's methodology was problematic and unclear, he offered generalised and unsubstantiated comments on the nature of women offenders and provided no definition of personality disorder, although he maintained that 53% of his sample suffered from it. Such problems did not, however, deter the Labour Home Secretary, James Callaghan from announcing in December 1968:

the main feature of the programme to re-shape the system of female penal establishments in England and Wales was to demolish the existing prison at Holloway and build an establishment that was basically a secure hospital. The central features would be medical and psychiatric facilities and normal custodial facilities would comprise a relatively small part of the establishment. Moreover, the new Holloway was to be designed so that, if and when it was no longer needed as a prison, it could be handed over to the National Health Service and used as a mental hospital ..... It seems that from the outset the Holloway Project Group only wished to consult research supporting their pre-conceived ideas and these appear to continue in the vein of psychological and physiological explanations that had come to dominate thinking at that time (270).

In 1971, D. Faulkner, the chair of the Holloway Development Group and Assistant Secretary in the Prison Department discussed its philosophy in the Howard Journal. Women were classified not in relation to "their sentence or offence, but rather in terms of the treatment they required" (271). The building was to be constructed so that it would not resemble a prison:

The entry point was to be made informal and reassuring and, according to Faulkner, the buildings were to be centred on a green 'to give an open aspect and an appearance of freedom while preserving a high degree of supervision' (272).

People in Prison an official Home Office report published in 1969 supported this view. While the anonymous authors pointed out that 85% of women in prison for that year were incarcerated for offences against property, prostitution and drunkenness, it concluded "many women in custody are dearly in need of medical and psychiatric treatment". It went on to note:

because most women and girls in custody require some form of medical, psychiatric or remedial treatment, priority will be given in the redevelopment of Holloway to the construction of a new hospital. It will thus become a medically-orientated establishment with the comprehensive, versatile and secure hospital as its central feature (273).

By the early 1970s this medicalised view of Holloway's philosophy and practice had become institutionalised. John Camp's analysis of the prison, published in 1974, provides a good insight into the direction of the regime. He reiterated the view that the prison would be "more akin to a hospital" than a prison and outlined the three main aims of the prison. First, any woman who had family problems would be assisted. This included meeting children from school and providing meals. Second, there was to be "long-term treatment in various forms." This included psychiatric treatment when required and "education for the illiterate and backward and various forms of group counselling and therapy." Finally:

there is the provision of a community life in prison modelled on life outside which will prepare the woman for coping with a normal existence from the moment she enters Holloway and which will include tuition in various skills which may augment her income on release, improvement in her ability to communicate, introduction to hobbies which she can pursue in her leisure time and information as to where she can turn to for help in the community if she finds herself in difficulties. It is hoped that by this means she will be taught not only to lead an honest life but also a reasonably happy one, which so many women who come to prison have never known (274).

From this perspective, the problem of women's deviance lay very much within the individual whose behaviour thus had to be normalised in order to return them as rehabilitated individuals into the community. Camp indicated how this perspective was reinforced by changes in the categorisation procedures where the women would no longer be grouped according to their sentence or offence, but "in terms of the treatment they require". Five main units were to undertake the "various kinds of treatment". These included medical, surgical and obstetric units for physical care and a psychotherapeutic unit for drug addicts and alcoholics. Additionally:

there will be a psycho-diagnostic unit for treatment of the highly disturbed or those experiencing the effects of drug addiction or withdrawal and ..... there will be a unit for those serving sentences (including Borstal recalls and normal trainees) who are not in need of definite medical treatment but who may benefit from the attention of a psycho-therapist (275).

Medical surveillance was to continue on the outside with the provision of an out-patients department which would provide a "full range of clinical services both to supply medical and

psychiatric reports to the courts and also to provide continuing out-patient treatment for those who require and desire it after release" (276). The staff too were to participate in medical training where "great attention" was being given to the psychiatric approach to offenders. In particular group counselling was an important part of the training which itself was to be augmented by two or three week secondments to institutions which specialised in psychiatric medicine including Broadmoor, the Maudsley Hospital and Grendon Psychiatric Prison. Camp was quite clear about the implications of such psychiatric treatment for women: "she has committed an offence and is not fully responsible for her actions and must be taught what is best for her" (277).

Carol Smart captured the essence of the debates around women prisoners at the time. Describing the development of the psychiatric regime at Holloway and the power of the medical profession within it she contended:

The aim of the programme of treatment in Holloway will be to achieve conformity in its inmates through modifying their personalities and attitudes. In embracing such a goal the role of the legal system, the police and courts, as well as an inequitable social system, in the process of criminalization, is entirely ignored. Moreover, the treatment programme may also be indicative of a change in the conception of the motivational basis of criminality away from the classical concept of responsibility towards a more positivistic orientation which emphasizes individual pathology. In this respect changes in penal policy appear to reflect trends in criminological theories about female criminality which also adhere to a pathological mode. Apparently policy-makers, like many criminologists, perceive female criminality as irrational, irresponsible and largely unintentional behaviour, as an individual maladjustment to a well-ordered and consensual society. Yet as well as sharing basic assumptions, criminological theories of female criminality may serve to legitimize



the trends in penal policy, giving scientific justifications for the treatment of female offenders as 'sick' individuals. Such legitimization follows from the confirmation of certain cultural understandings of female behaviour in general and criminal behaviour in particular and is a consequence of the failure of criminological theorists to explicate or treat as topics for analysis the understandings which they share with those engaged in the formulation of social policy (278).

The final touch to the programme, and one which continued the tradition established in the nineteenth century was the appointment of South African born Lady Megan Bull as prison governor. She had been M.O. at Holloway since 1967 and was appointed to succeed Dorothy Wing who retired in February 1973 (279).

The appointment of a doctor to the post of governor has, as I have noted a long history in women's prisons and symbolised the direction of prison regimes for women through the nineteenth and into the twentieth century. At the same time Megan Bull's appointment did not herald a new beginning in the psychiatric treatment of confined women. On the contrary, by the late 1970s the ability of psychiatry and medicine to alter the behaviour of women prisoners was the subject of critical and often sceptical scrutiny. This is not to say that psychiatric discourse was eliminated from the penal regimes for women. It remained a central, and as I shall indicate, contradictory element in the everyday lives of the confined. It did, however, take its place alongside other developments, most notably official pronouncements concerning the changing nature of women's criminality. Official spokespersons talked of the prison population as "depressingly normal" or as the Assistant Director of Prison Medical Services expressed it in 1978:

When the new Holloway was begun there was a very much higher percentage of female offenders who appeared to be psychiatrically disturbed, there are fewer who are psychiatrically disturbed in relationship to the total number than there were before. There are normal but difficult people in the system (280).

Other evidence to the House of Commons Expenditure Committee in 1978 re-emphasised the disturbed and inadequate nature of the female prison population. One sister from Holloway told the Committee that "perhaps five per cent are normal. The rest are disturbed" (281). Such contradictory perceptions were to underpin the responses and programmes that women in prison were to face in the late 1970s and through the 1980s. Either as individuals or in groups, the women were continually under the penal microscope with every movement, gesture and response magnified and recorded by those who observed them.

#### Consolidating Contradictions.

The 15th Report of the House of Commons Expenditure Committee was published in 1978. The introduction to the report called for a separate inquiry into women's imprisonment which the Committee undertook in late 1978 and early 1979. However, because of the 1979 General Election the report was never written. The National Association for the Care and Resettlement of Offenders (NACRO) reviewed the evidence to the Committee in its 14 page document Women in the Prison System, published in 1980 (282). NACRO's report pointed to a number of areas of concern including a major increase in overcrowding, the problems

of mothers and babies in prison, and the distance from family and friends which led to a lack of contact with the outside world. The report also highlighted the continuing disruption in the prisons. This disruption took different forms including assaults, self-mutilation, ear-piercing and self-strangulation. As in the nineteenth century this behaviour was explained in psychiatric terms, the women were treated as abnormal with drugs being used in some prisons to regulate and discipline their behaviour. NACRO pointed out that there was no consensus that the majority of women prisoners were in fact mentally ill. The Prison Officers' Association (POA) saw them as "sophisticated, callous and cunning" while the Home Office argued that the female prison population "is depressingly normal and that a large number of the women are normal women ... " (283). In January 1981, the Home Office confirmed the new direction that Holloway was to take. In an internal memorandum sent by P 4 Division to, amongst others, Dr Orr, the then Director of the Prison Medical Service, the writer pointed out that delays in the building of the prison had allowed the Prison Department to take account of the changed situation. In particular "it has become clear that the needs of the female inmate population have changed markedly since 1968" (284). The Department pinpointed three main changes. First, the rise in the female population to a figure of over 1500. Second, the number of women being sentenced to longer terms of imprisonment. The memorandum indicated "the number of prisoners serving over four years has trebled since 1970" (285). Finally, the Department argued that the nature of the prison population had changed:

The development of Holloway was based on the proposition that most women and girls in custody required some form of medical, psychiatric or remedial treatment. It is now clear that the prison service is receiving an increasing proportion of women whose crimes, circumstances and personalities do not call for such specialised help. In many ways they have characteristics similar to that of the male population (286).

From this overview, it concluded:

these factors and the realisation that psychiatry has little to offer in the treatment of criminality, have combined to make it impossible to justify the high expenditure and heavy emphasis on medical and related facilities and have made it necessary to allow for the development of a training regime for a larger number of women (287).

The Department maintained that while Holloway would continue to play a central role in providing the required medical and psychiatric facilities for both young and adult female prisoners:

that will no longer be however, its sole or primary focus. Its primary intention will be to provide a training regime for sentenced prisoners, and remand facilities and services as a local prison for unconvicted and unsentenced inmates. The prison will therefore share with other local and training establishments in the prison system the objective of providing for the positive custody of its inmates, with education activities and occupational employment provided within a disciplined but caring regime (288).

One further consequence of this shift was that the level of security was being enhanced while "provision is also being made for a segregation unit" (289). The fact the Department had declared that Holloway was now to be a "disciplined but caring regime" did not prevent the utilisation and applica-

tion of psychiatric and psychological concepts within the prison setting. At the same time the resurrection of security and control in the context of the 'normal' dangerous woman offender meant that prison managers could also legitimately increase and intensify the level of regulation and surveillance to which the women were subjected. As I have indicated such individualised surveillance strategies have been an integral part of female prison history. By the 1980s electronic monitoring had augmented the gaze of the professional prison visitor and the medical doctor. The experience of women in H Wing of Durham prison is a good illustration of the twin processes of individualisation and surveillance. According to one ex-prisoner:

The only way I've ever been able to describe Durham is like a submarine - I've never been in one but I imagine that's what it's like. You couldn't see daylight. It felt like you were buried alive. That was your life in there. It was as if the world outside didn't exist. If I stood on my bed and looked out of the window with its four sets of bars, all I could see was a big high wall with a tiny bit of tree over the top. We used to climb on the sink unit in the bathroom and look through a little window so you could see far away the hills and sometimes you'd see a little tiny car going along them. You really felt the need to see the outside world sometimes, just to make sure it was still there. When you went out on exercise, it was just in a concrete yard with a wire fence round it, no trees, no grass. There were dogs and male officers patrolling with walkie-talkies around the outside and the inside. Four cameras watching you, following you. All you could see were brick walls. The men from the men's part of the prison had their cells overlooking the yard. They'd shout remarks as we walked round. Sometimes they could be very abusive. In Durham you weren't allowed to think for yourself, you couldn't do anything. Everything you did was monitored, you couldn't get away from it (290).

In March 1984, the wing held 36 prisoners, three of whom were

in the top security Category A (291). During the year the women had to slop out; cell association was limited to three at a time with the doors continuously opened; food, drink and conversation was prohibited in the two main T.V. rooms; cooking facilities were not allowed; education was basic and exercise was taken in a tarmac yard which was surrounded by a 20 foot wire fence topped with coils of razor-sharp barbed wire and a high perimeter wall. Overall:

The keyword is perpetual surveillance, there is little privacy, even the toilets are fitted with half doors, leaving a psychological impact on the mind with the very real effect of constipation, one of the many problems of life on 'H' Wing .... The women are monitored by closed-circuit TV cameras, female officers and male officers regularly patrol the area between fence and wall with ferocious-looking guard dogs (292).

Former prisoners have indicated that the conditions had a detrimental effect on their physical and psychological health, including loss of energy, hair and memory, becoming withdrawn, eyesight problems from the fluorescent lights and skin changes in colour and texture (293).

By 1985, there were 39 women on a wing which used to contain 20 male prisoners. In that sense, "the overcrowding affects every aspect of the women's lives" (294). While a number of minor concessions had been made with regard to cooking and education, overall women on the wing "must struggle to regain even those privileges that the men had on the same unit a decade ago when it was closed down because the conditions were inhumane and unsuitable for long-term imprisonment" (295). This unsuitability

manifested itself particularly in the psychological impact the wing had on the women:

It is a medical fact that lack of privacy causes stress. Everything women do on H Wing is monitored by camera, operated by men or the ever present prison officer. The toilets don't have locks and have short stable doors which one doesn't have to be a limbo dancer to get beneath. God help the inmate who should mistakenly or out of despair go out of turn to use one of these toilets, for to go to the toilet when in the workroom one has to go down on a list. If she goes out of turn, she risks the embarrassment of further degradation of having one of the screws, arms akimbo, on top of the cubicle door demanding to know "what are you doing?" with the further possible risk of being placed on report if she tells her.

I am having to come to terms with a recurring urinary tract infection and hormone problem. But this isn't surprising considering the strain put onto the bladder, kidney and bowels by being made to wait in turn one at a time to use the toilets in the workroom and trying to avoid the potty during lock in. There is the unavoidable further degradation of the slop out when unlocked, usually whilst the food is being set out directly below the slop-out recess.

No light penetrates within H Wing walls: fluorescent lighting has to be in continual use. I entered the prison with 20-20 vision and had to wait nearly 5 months before an optician examined me. I am now having to adjust to wearing glasses for the rest of my life. Many women's periods stop and schizophrenia and paranoia are prevalent (296).

These characteristics were reinforced by the enforcement of petty rules and regulations. Furthermore, the use of strip and cell searches had become part of the daily routine. The searches were carried out after visits by probation officers, solicitors, friends and relatives while rub down searches were employed daily when the women entered and left the workroom, the exercise yard and the gymnasium. The prisoners protested at the conditions. Early in 1984, 23 of the 35 women on the wing engaged in a hunger strike. In 1985 they protested at the medical treatment of one prisoner who was:

badly in need of medical attention. The doors at night are on a time-lock and cannot be opened unless the Governor is present. My friend had to wait until the next morning. It was a nightmare of hours of lonely suffering and possibly danger to her life, dependent on the decision whether to wake the Governor or not (297).

Others turned in on themselves. Maria Szigmond, committed suicide in 1978, on her fortieth birthday. According to one ex-prisoner:

Maria Szigmond was a Hungarian refugee and was involved in a series of tragic incidents which led to her being separated from her husband. She felt unable to cope and decided that she would kill her son and herself. She succeeded in killing her son but not herself, even though she had taken an enormous number of pills. She was tried for murder and sent to Durham H-Wing. At Durham she asked for psychiatric help but wasn't able to get it in Jail. She decided to try and kill herself again on her birthday by hanging herself in her cell. She knew what it looked like when someone was hung because of her son, and so she decided to make it as easy as possible for the officers when they found her. She put a pretty scarf around her eyes and one round her mouth, and a sanitary towel down to stop the discharge. And then she hanged herself with the cord she'd used to hang her son. She wasn't found until the morning at eight o'clock (298).

For younger women, debilitated by the "dreary monotonous routine and £100,000 of space age technology" underpinned by the imposition of petty rules and regulations "it is small wonder they usually end up behind their doors on report, or get 'doped' up to dull their minds" (299).

Accounts by other prisoners confirm the constant and complex series of rules and regulations which govern their behaviour inside. At a general level women are disciplined more than twice as often as men. In 1986, as Una Padel and Prue Stevenson have pointed out, "3.6 offenders were punished per head of the female



prison population as against 1.6 per head of the male prison population" (300). Many of these disciplinary infractions could be seen to arise from the intensive enforcement of the petty rules and regulations:

Every morning, even Saturday and Sunday, we were woken at seven. We had to be washed, dressed, have our hair immaculate (which was difficult because I had to plait mine), strip all the bedclothes off our beds (which seemed totally a pointless exercise and got right up my nose the entire time I was at Styal), and fold them to a complicated and immaculate design - sheet, blanket, sheet all wrapped round with the counterpane and put at the end of the bed. All that and down to sign the time book by 7.20. You had to queue to sign the book, as only one inmate was allowed in the office at a time. If you're late twice you're put on report, and girls often lost remission because of that. Twenty-two women, eight washbasins, two toilets, it's just impossible; twenty minutes to do all that and bunk your bed as well, and if you're sleeping in a bunk in a crowded room you're falling over each other trying to fold your sheets and blankets at the same time. I got it down to a fine art, but it was all additional pressure. Some screws were more lenient than others and you learned when you saw who came round to wake you up how much you had to hurry - whether it was one who'd put you on report if you were one minute late or if they would give you five minutes' grace. Some were really heavy (301).

As Pat Carlen has indicated, the enforcement of hierarchical discipline in this way combines:

with the domestic work programme, with the denial to prisoners of sociability and adult womanhood and with the organization of women into small family units, to ensure a mental and bodily surveillance which denudes the prisoners' daily life of all dignity and independence (302).

In the majority of prisons hierarchical authority retains its nineteenth century legacy in that the positions of authority are occupied by men. When Polly Toynbee visited Bullwood Hall in

March 1983 she found the young women were faced with a hierarchy in which the governor was a man as was the person in charge of the kitchen, the factory, the workshops, physical education and the probation and religious services. The doctor was also a man who visited the prison two half days a week to operate the therapeutic unit. When it was pointed out that men were set above the prisoners to the possible detriment of their self image he argued:

.... 'you couldn't have all women! The place would be rife with pre-menstrual tension and, no sanity anywhere!' Here he mentioned in passing that he had thought of instituting menstrual charts to see if there was a correlation between violence and menstruation but this had to be abandoned according to the deputy governor since girls kept asking for Tampax to use the outer wrappers as cigarette papers (303).

What is also clear from these accounts and recent research on women in prison is that the long march of medicine from the beginning of the eighteenth century to the present, is still a central factor in the response of the criminal justice system in general and prisons in particular to criminal women. Medical and psychiatric power pervades and percolates the institutional practices and individual ideologies of state personnel. This cuts through all aspects of imprisonment. At the pre-trial stage, remanding women for medical reports mobilises a series of comments and images from prison medical personnel. It is a set of images quite distinct from those which find their way into reports on male prisoners. As Hilary Allen has noted:

The privilege that the women's prisons have accorded to psychiatry, is also evident in the reports and recommendations of their resident doctors. Unlike

the closely circumscribed reports from male prisons, the medical reports on women prisoners are complex documents, containing statements on a whole range of biographical, social, moral, criminal, psychological aspects of their subjects' lives, as well as a detailed discussion of their mental condition. Expectations of extensive medical authority and expertise are also reflected in the conclusions of these reports. Whether or not any mental disorder is diagnosed, medical officers from the women's prisons quite routinely include detailed reflections on the ideal sentencing and management of the offenders concerned. In these reports one rarely finds the dismissive formula that concludes so many male reports: 'I can find no evidence of mental disorder and have therefore no recommendations to make' (304).

The use of psychiatric labels such as "personality disorder" continues to reinforce the subordination of the women. As Pat Carlen has argued, although it cannot be defined the application of the label makes:

imprisoned women ..... feel 'quite horribly at home' within psychiatric careers ... whilst both the history and the present organization of psychiatric and penal internment in Britain are particularly suited to disciplining women into what is still regarded as being Scottish woman's most proper role, that of the child-rearing home-maker (305).

Normalisation through psychiatry is underpinned by other medical mechanisms for maintaining order and control. As Chapter 5 indicated, psychotropic drugs have become an important element in that control. In women's prisons, such drugs have been used disproportionately in terms of the rate of prescription per head of the prisoner population (306). Carlen described how one doctor saw this process:

Pat Carlen: 'What drugs do you provide?'

Doctor: 'You name it - we give it, depending on the case and what they've been prescribed outside. If a person has been on an anti-depressant for a medium term and is telling us that it is doing them good then we'll continue it. If they tell me they've been on it for years and it's doing them no good, then we try to stop them.'

Pat Carlen: 'Do you ever give drugs for control purposes - for controlling violent prisoners?'

Doctor: 'Yes. We have to take the staff into consideration when selecting a drug. Some people we've had in eight or ten times in two years and you know they can be pretty wicked without the drug' (307).

More recent research in the area has confirmed this view. Mandaraka-Sheppard observed what she described as the use of "heavy sedation" in the course of her research. The drugs were part of a network of control designed to prevent escapes and quell disturbances by:

so classified 'hard core troublemakers'. This research has shown that such classifications (at least as far as women prisoners are concerned) are arbitrary and have negative repercussions. There was no evidence by which to identify such troublemakers; they are, it would appear, likely to be the result of the system's use of harsh social control and labelling procedures which are negatively perceived by prisoners .... The argument concerning 'disturbed' prisoners has been accepted with complacency; the result has been to introduce psychiatric methods and psychotropic drugs of therapy in prisons, which, under the guise of 'benevolent treatment' have resulted in abuses for the purpose of social control and not for the genuine help of the prisoners (308).

Elaine Genders and Elaine Player have indicated that between January 1984 and March 1985 over 145,000 doses of anti-depressants, sedatives and tranquillisers "were dispensed to women in prison-proportionately five times as many doses of this type of medication as men received in prison". They concluded:

it is a complex and uneven picture with different prescribing practices operating in different establishments .... There were, however, common themes which did emerge. From interviews with prison medical officers and nursing staff it was made plain that although medication was prescribed for women who were considered to be suffering from mental disorder, many prescriptions were issued for women who were not diagnosed as being 'sick' or suffering from a pathological condition. Instead, the women were described as having 'normal' difficulties in coping with the problems associated with their imprisonment and medication was seen as helping to alleviate some of the more acute pain they were suffering (309).

In this way the structural questions around the prison regime, its philosophy and practice are translated into individual psychological problems situated on a coping non-coping continuum. The place of medicine in the everyday lives of confined women is compounded by the more general question of the medical treatment which they receive. As I have indicated, historically this has been a controversial issue in women's prisons. The doctrine of less-eligibility analysed in previous chapters has been compounded by the refusal to acknowledge the particular problems which women experience with regard to health care (310). As in the previous 150 years, the issue of health care has underpinned the more recent debates in relation to the deaths of women in custody. Both this and the previous chapter have shown that such deaths are not a recent phenomenon but stretch back to the early days of the P.M.S. According to Melissa Benn and Chris Tchaikovsky, behind the latest statistics "is a story told by prisoners, ex-prisoners, prison reform groups and official sources, of fire hazards, medical neglect and preventable suicides" (311). The report published by the Women's Equality Group in the London Strategic Policy Unit in 1986 highlighted a number of these deaths. In focussing on the deaths the report's authors argued that:

Nothing highlights the urgent need for a complete change in the use of imprisonment in this country more than this account of deaths in custody. Emergency bells bent back or not answered, access to doctors denied, suicide threats ignored, suicide attempts disregarded, and most fundamentally, women suffering severe mental or physical illness remanded in custody or even sentenced to imprisonment. Women are sometimes sent to prison in the mistaken belief that they will receive good medical care or to undergo psychiatric assessment .....

..... Prisoners seen to be a suicide risk are often kept in stripped cells - the emphasis is entirely on depriving the women of the means to kill herself rather than offering any counselling or other help (312).

The report made 10 recommendations with regard to the issue. These included: a recommendation that women should never be remanded in custody for psychiatric assessment, prisoners should never be assumed to be malingering if they threaten or attempt to take their own lives; and "prisoners should be afforded the full protection of the NHS, the Prison Medical Service should be abolished" (313).

While death has been the path chosen by some, others have engaged in disturbances and self mutilation in response to the regime. As I have indicated, this pattern of behaviour has also a long history in women's prisons. Again, it has continued into the 1980s. Holloway's notorious C1 Wing which opened in 1977 has been a particular source of controversy and concern. In October 1984, The Guardian reporter Polly Toynbee discussed the Wing's problems (314). She was distressed at the number of "so many deeply deranged and disturbed women" in the prison and questioned whether they should be there at all:

With some it is immediately clear that they are urgently in need of full-time psychiatric care in a secure hospital. For a prison 'psychiatric' wing is nothing more than a dumping ground, a containment for them. The atmosphere is punitive not therapeutic, the prisoners' mad outbreaks and attacks are regarded as punishable rather than treatable and the psychiatric care they can expect in any prison is nothing more than a parody of proper treatment (315).

Since that time, the punitive and contradictory nature of the regime has been highlighted by MPs, newspapers, pressure groups and the prisoners themselves. They have focussed on the recurring self-mutilations and suicides as well as questioning the nature of the disciplinary hearings at which women suffering from mental disorders have been punished. They also revealed that "Home Office advice on the treatment of mentally ill inmates is being ignored by medical staff" (316). For William Bingley, the Director of MIND, Holloway's problems were the same as those "endemic in the rest of the prison system. They follow from the separation of the prison medical service from the mainstream National Health Service" (317). In March 1986, Nick Davies, The Observer's Home Affairs Correspondent visited the prison and once again illustrated the inter-relationship between containment and medical therapy. While what he termed "the last vestiges of a medical regime still survive on the wing" its philosophy was towards containment and control:

Safe containment thus becomes the torment of hours alone in a bare cell with every potential distraction removed - an experience which inevitably makes sick women sicker. In an attempt to make it safer still, builders are now constructing a padded cell on the wing - the ultimate paradox of humane treatment as solitary confinement (318).

Davies pointed out that the wing was staffed by prison officers who had no medical training and by nurses who had no psychiatric training. Additionally, some of the nurses were employed for short spells from an outside employment agency. Finally, he noted that the women on the wing were punished "more often than other prisoners, particularly for damaging prison property and disobeying orders" (319).

### Contesting Power.

As I have noted throughout this thesis, the Prison Medical Service has not developed and consolidated without challenge. I have indicated that during the twentieth century the challenges mounted by prisoners have been supported by groups outside of the prison walls. The work of the Prison System Enquiry Committee in the first decades of the twentieth century, the pamphlets of the Prison Medical Reform Council published between the 1940s and 1960s and the interventions of the National Prisoners' Movement and Radical Alternatives to Prison in the 1970s and 1980s have all provided alternative accounts of life inside in general and challenged medical hegemony in particular. In March 1983, the formation of Women in Prison (WIP) carried on this tradition. The 10 point manifesto of the group called for amongst other things "improved medical facilities in general and specialized facilities for women during pregnancy, childbirth and menstruation" (320). The manifesto contained a further 10 points relating to prisoners in general. Point 6 of these demands argued for:



[the] abolition of the Prison Medical Service and its replacement by normal National Health Service provision coupled with the abolition of the present system whereby prison officers vet, and have the power to refuse, prisoners' requests to see the doctor (321).

The report by the Women's Equality Group of the London Strategic Policy Unit, published in 1986, had a strong input from the group. The report made 10 recommendations around women's health in prisons. These included: a call for the abolition of the P.M.S.; the right of a prisoner to choose her own doctor; the non-involvement of doctors in discipline and the sanctioning of punishment; the rejection of the use of medicine for punishment, control or disciplinary purposes; and finally the call for women prisoners to "have the right to ask to be treated by women medical staff" (322). Since its formation WIP has been campaigning, holding public meetings, picketing prisons, appearing in the media and writing to MPs and prison officials about conditions in prison. It has gathered and disseminated a range of information and alternative accounts of life in the prisons. Since 1983, one forum for that dissemination has been a regular contribution to The Abolitionist, the journal of Radical Alternatives to Prison. The group has produced accounts by prisoners of life inside in general, and prison medical facilities and treatment in particular. Various editions of the journal have contained powerful accounts of medical treatment and the lack of sensitivity to the medical problems facing imprisoned women (323). The group also launched a project on women in special hospitals in the light of the fact that "prisoners are regularly transferred from prison to Special Hospitals under a variety of orders" (324). It noted that there

were 400 women in special hospitals at any one time and illustrated the relationship women have had with these institutions. In 1983, of the 297 men and women discharged 69% of men and 80% of women were "conditionally discharged and therefore liable to recall. Two per cent of men and five per cent of women had been detained for over 30 years, that is since their original committal or last recall" (325). WIP has also highlighted the issues around the question of mothers and babies in prison as well as the disproportionate use of strip-searching on women prisoners, an issue which signifies the surveillance and continuing scrutiny of the minutiae of their existence. As with the previous campaigning groups that I have highlighted, the work of Women in Prison has provided a focus for resistance and a forum for women prisoners to articulate their grievances around medical care and conditions inside. The group has, in short, challenged medical power and provided a counter-weight to the development of a full-blown medical hegemony in women's prisons.

The relationship between prison medical power and confined women, is, as I have indicated, a complex one. From the historical and contemporary material presented in this chapter it is possible to discern a number of themes running through this relationship:- the individualisation of women prisoners; the drive to normalise their behaviour; the close interconnection between different, usually male-dominated professional groups whose activities have been built on the perpetual surveillance of the women's physical and psychological response to imprisonment; the advent of intensive technological control from the 1960s; the resistance of women to that control and to medical and psychiatric categorisation; and

the continuing entrapment of women within catch-all psychiatric categories such as behavioural and personality disorder. As Pat Carlen has pointed out:

As it is not acceptable to say publicly that people are sent to prison because of their social circumstances, the actual social reasons for imprisonment .... are, in public, displaced on to the psychiatric category of psychopathic personality disorder and this category is then used by prison personnel to justify all aspects of the prison regime. Women are actually sent to prison because of either their domestic circumstances, the failure of non penal welfare or health institutions to cope with their problems ... or their failure to comply with socially-conditioned female gender-stereotype requirements. Once there, they are treated to a disciplinary regime which engenders confused states of consciousness by contradictorily defining them as both within and without family, femininity, adulthood and sanity (326).

It is within this disciplinary matrix that medicine operates in women's prisons, ultimately reinforcing the fragmentation that imprisonment engenders in the already fractured psyches of the women at the centre of the professionals' gaze.

Chapter 7

Uncovering Medical Power.

At the beginning of his Discipline and Punish Foucault puts the question to himself, why, now, write a history of the prison? 'Simply because I am interested in the past? No if one means by that writing a history of the past in terms of the present. Yes if one means writing the history of the present' (1).

In Chapter 1 I indicated that this thesis owes a theoretical debt to the insights developed by Michel Foucault in relation to confinement. The disciplinary genesis of institutional medical power, the analysis of resistance to domination and the non-reductionist view of power that he presents have all been central to the dissection of medical power in English prisons. At the same time, the substantive material in Chapters 3-6, has itself, raised some important theoretical questions in relation to Foucault's work. In this final chapter, I wish to explore some of these questions and interrogate the limitations in his work which derive from such an exploration. There are three areas in particular which have developed out of the substantive analysis. These relate to questions of gender, violence and the state.

#### The Limits to Foucauldian Methodology.

While the question of medical classification and control is central to Foucault's and Stan Cohen's analyses both fail to consider in any depth the differential impact that gender has in the classificatory process. Put at its simplest, the power to classify and the practical and political impact of that power varies with gender. As Chapter 6 illustrated medical and psychiatric classificatory procedures have had a differential impact on male and female prisoners. The essence of their criminality and the threat

that each group posed to the social order was perceived differently by the professionals who analysed them, by the courts who sentenced them, by the gaolers who confined them and by the medical personnel who categorised them. This inter-locking network of power therefore responded to what were regarded as important differences in the origins of male and female criminality and constructed different regimes to deal with that criminality. In that sense, then, the power/knowledge/discipline axis which both Foucault and Cohen identify varied with gender.

As I argued, confined women, historically and contemporaneously, have been the subject of an intensive level of surveillance. The policies and practices of prison regimes have been orientated to breaking down the social body of women prisoners into individualised, manageable units. This process of individualisation has been a cornerstone of women's prisons. State servants, professionals and prisoners themselves have seen it as something which is more clearly articulated in relation to female prisoners than to their male counterparts. The surveillance which is integral to these practices has been carried out by different groups from chaplains, to lady visitors to medical personnel themselves. The latter group involving doctors, psychologists and psychiatrists as well as psychiatric social workers beyond the walls have tested, probed and hypothesised about criminal women constructing quantifiable profiles of the bio-psychological and narrowly defined sociological factors, deemed to be lying at the root of their criminality. Such investigations have been further intensified in dealing with those who respond negatively to the prison

regime. As Chapter 6 illustrated, throughout the nineteenth and into the twentieth century women prisoners have responded differently from men to the pains of confinement in terms of physical self-injury and psychological introspection. This has been a central aspect of women's imprisonment, although it should be noted that there has also been a strong element of collective support and resistance to the prison regime. Such individualised responses have generated further medical intervention into the lives of women prisoners reinforcing the view that it is they rather than the pressurised structures and policies of the prisons that are at fault.

The generation of psychological profiles, the construction of a knowledge base and the different categorisation procedures utilised have been orientated to normalising the women back to domestic respectability. In that sense rehabilitation for women has meant the domestic normality of motherhood and home. The key Foucauldian concepts involving order, control, routines and time-tables built around this knowledge base have been translated into a very different practice in women's prisons in the shape of the work programme, motherhood courses and domestic education classes. I shall return to this question of gender when dealing with Foucault's theorisation of the state.

### The Issue of Violence.

A second limitation in both Foucault's and Cohen's theses revolves around the issue of ethnocentrism and violence.

The system of power that they analyse and the relationships that flow from it are applied narrowly to Western Europe and North America. They fail to consider how the power to punish was exported to, and utilised in, colonial situations and in turn was reflected back onto the punishment apparatus of the original exporter. Violence was endemic in this process (2). This point has specific reference for Foucault's idea that with the rise of capitalism and professional expertise punishment moved from the body to the mind. At one level, such a conceptualisation undoubtedly 'fits' with the emergence of psychiatric practice in Europe and America. However, it misses an essential point, namely that physical violence and punishment of the body did not, and has not, disappeared but remains and retains a central place in the repertoire of responses mobilised by the state inside prisons. Autobiographical accounts by male and female prisoners from the mid-nineteenth century to the present, which have been utilised in the thesis, testify to the centrality of violence in the maintenance of order. Recent accounts of the operation of the criminal justice system in general (3), as well as prisons in Scotland (4), Northern Ireland (5) and Nigeria (6) in particular, have only served to emphasise this point still further.

Both Foucault and Cohen overemphasise the nature of the shift in punishment that has taken place and underestimate the complex and continuous inter-relationship between punishment of the body and control of the mind. While displays of torture, violence and execution may have disappeared from the public domain they still exist and operate in the various institutions that have



developed since the late eighteenth century. As Chapters 3, 4 and 5 indicated, medical and psychiatric discourse did not simply replace physical punishment of the body, the two have continued to co-exist with the latter strategy being mobilised when the institution has been threatened or when prison officers feel aggrieved or affronted by the activities of an individual or group of prisoners. In women's prisons where the psychiatrization of the confined has developed the furthest, physical violence against the confined will still be mobilised to deal with problematic behaviour. Even in the 1950s, when as I illustrated in Chapter 3, the psychological examination of prisoners was receiving its greatest praise and seemed ready to finally uncover the roots of criminality through the exploration of the mind, physical violence remained as one response by the state to prisoner protest. Heinz Steinert has made a similar point in relation to Foucault's theorisation of violence:

Alongside the discourse on punishment, the prison and their scientific "humanization" worldwide, we still have torture, people being beaten and dying in prison. We have concentration camps: we have the death penalty in the majority of countries. There remains a lot that is not accounted for by a Foucault-type analysis of history. The picture may be even darker than the one Foucault presents to us, but it is also a bit more contradictory. The seemingly closed inevitability of the system is a product of a certain kind of analysis. Yet what appears so compact and elastic is also fragile and just barely held in balance (7).

Steinert raises a third dimension in his critique which I wish to explore and which has developed out of the analysis in this thesis. This relates to Foucault's conceptualisation of the state.

The Question of State Power.

Steinert argues that Foucault's analysis of the politics of power and control could be termed "administrative history". He contends that while administrators such as doctors, forensic psychiatrists and teachers (who form the front-line of control in Foucault's analysis) are a fundamental level in the hierarchy of domination, this account is too dependent on an interpretation of the influence of these front-line controllers:

..... this is certainly a very interesting level in the hierarchy of control, but also one that knows and tells more about the ideologies and well-meant intentions than the realities of control. The control-fantasies at this level may either mean next to nothing or a great deal depending on the institutional arrangements, available for making the 'first line' controllers even try to act them out (8).

As I have indicated, those who have staffed the P.M.S. have indeed been important as "first-line controllers" since the end of the eighteenth century. Their position has been facilitated because of the institutional arrangements inside the prison which gave medical personnel the autonomy, discretion and laboratory to work through their ideas about criminality and health care. These arrangements themselves were tied to wider concerns around discipline, regulation and control which were explored in Chapter 4 and importantly to the development of an interventionist and increasingly centralised state from 1877 onwards. This dialectic became even more pronounced in the post 1945 period when as Chapter 3 indicated, the ideology of social reconstruction, the power of professional groups and the increasing level of state intervention into post-war English society all contributed to, and provided the legitimacy

for, the medical profession's work. In that sense, then, while the power of the doctors to manage the prisons and to make interventions into debates about criminality was a central element in the development of the prisons in the post-war period, this power did not operate in a vacuum. It was tied to, and reflected in, the wider debates about criminality, social control and social order which were an integral part of political discourse at the time. While they may have had autonomy, medical personnel did not stand outside or above these processes, many of which were conducted through or co-ordinated by the bureaucracy of the post-war state.

This point has been taken up by Boaventura De Sousa Santos and Nicos Poulantzas. De Sousa Santos argues that Foucault is correct to stress the existence of power relations that operate outside of the state. However:

he goes too far in stressing their dispersion and fragmentation. He is left with no theory of the hierarchy of power forms and no theory of social transformation. He obscures the central role of the power forms of the citizenplace and the workplace in our societies, domination and exploitation respectively (9).

He further criticises Foucault for ignoring the complexity of Marxist critiques of the state and for not going far enough with regard to the question of state power:

He takes the conventional critical wisdom about the state for granted, in that he conceives state power and law as a monolithic entity and reduces it to the exercise of coercion. This leads him to overstate the mutual incompatibility of juridical power and disciplinary power and to overlook the subtle inter-

penetrations between them (10).

For De Sousa Santos, recognizing the centrality of state power and law is "compatible with the recognition of the multiplicity of forms of power and forms of law in capitalist societies" (11).

For Poulantzas, Foucault's conceptualisation of the state is also misplaced as is the "peculiar caricature of Marxism" that underpins it (12). He argues that Foucault misrepresents his position on the state by simplifying how he theorised its operationalisation. The state in Poulantzas's view is neither:

the instrumental depository (object) of a power essence held by the dominant class, nor a subject possessing a quantity of power equal to the quantity it takes from the classes which face it: the State is rather the strategic site of organization of the dominant class in its relationship to the dominated classes. It is a site and a centre of the exercise of power, but it possesses no power of its own (13).

Additionally, and following from this, he takes issue with Foucault's conception of resistances to power seeing his theorisation as a "strictly gratuitous assertion in the sense that they are given no foundation: they are a pure affirmation of principle" (14). He rejects the idea that limitations can be placed on power only if a group escapes or breaks from its hold. On the contrary, power always carries with it "internal limits" of its own:

..... it is not that the State is an omnipotent entity beyond which lies emptiness; but already inscribed in its materiality are internal limits imposed by the struggles of the dominated (15).

Finally, he challenges Foucault on the question of violence, power and state practices. As I indicated above, both he and Cohen over-emphasise the shift that has taken place regarding the place of physical punishment of the body in Western Europe and America. This position underestimates the role of violence in contemporary state practices. For Poulantzas, violence occupies a determining position within the power relationships imposed by the state:

Physical violence and consent do not exist side by side like two calculable homogeneous magnitudes, related in such a way that more consent corresponds to less violence. Violence-terror always occupies a determining place - and not merely because it remains in reserve, coming into the open only in critical situations. State-monopolized physical violence permanently underlies the techniques of power and mechanisms of consent: it is inscribed in the web of disciplinary and ideological devices; and even when not directly exercised, it shapes the materiality of the social body upon which domination is brought to bear (16).

As Poulantzas and De Sousa Santos indicate, the question of state co-ordination is problematic in Foucault's work. In relation to this thesis, the precise connection between individual professionals working in the micro situation of the prison institution and the wider concerns of the English state is a formidable one to unravel and uncover. Recent sociological work in the area has provided some important, though as I shall indicate limited, overviews of the problem. David Ingleby's insightful outline of the relationship between mental health and social order is one of the best examples of this work. He discusses the limitations of functionalist, liberal, Marxist and post-structuralist accounts of the relationship between professionals and social order (17). Other

writers such as Peter Sedgwick (18), and more recently Peter Miller and Nikolas Rose have also argued for a non-reductionist view of professional power. The latter while rightly arguing against a generalised view of medicalisation go further to suggest that while the conduct of personal life "has become a crucial mechanism in the exercise of political power" it is misleading:

we suggest, to find the hand of 'the state' behind all such innovations in political thought and strategies. Instead, we need to analyse the often sporadic, ad hoc and local emergence of detailed techniques and systems of rule (19).

These overviews suffer from their own limitations. First, (apart from Miller and Rose) they operate at a high level of generality and fail to include case study material and rigorous empirical examination of the theories expounded. Second, this generality means that theoretical concepts are taken and applied across societies and cultures to the detriment of cultural specificity. The global nature of the theories point to similarities between power structures in different societies while marginalising differences between them. Third, while the state is mentioned in these works, it is not interrogated rigorously or sufficiently clearly. Fourth, the differential relationship between professional groups, the state and the marginalised such as women, blacks and young people, is not considered or theorised.

In the case of England it is possible to identify important links at key historical moments between professional discourse and the state. Concomitant with the analysis in this thesis, Stuart Hall

and Bill Schwarz illustrate the developing relationship between professional groups and the state in the crucial years between 1880 and 1930. They point to the emergence of a range of new social subjects who became "potential objects for state concern". Within this political landscape:

Each social category required a whole battery of state and/or voluntary agencies in order to ameliorate the effects of each particular 'disorder'. As the state was progressively enmeshed in resolving, or attempting to resolve, these dysfunctions in the social system so specific bureaucracies and departments of state were adopted for their regulation. These apparatuses, together with the experts and administrators - the 'organic state intellectuals' of the period - assumed the positive role of producing and accumulating new knowledge about specific subjects and categories which came under their disciplinary regimes. The formation, expansion and diversification of particular state departments and ministries, the arrival of the powerful state administrator-intellectuals ..... and the use of a new philosophy of scientific administration were all institutional expressions of this process. In this way the machinery of the state began to be transformed and reorganized (20).

John Clarke's analysis of the management of delinquency between 1913 and 1930 outlines the growth of professional discourse in this area and, in particular, how an accurate conception of this growth:

may be that it constructed an ideology of practice - a set of representations of the social relations within which practice took place. State power in these fields was thus organized through the ideology of the professional (21).

It can be seen from this thesis that at major historical moments the state did increasingly intervene (in Gramsci's phrase urging, inciting and soliciting) into the prisons through its relationship

with medical professionals. The work of the early prison doctors in the decades up to 1877, which I discussed in Chapter 4, emphasised a particular view of criminality together with disciplined health care for the confined. In that sense, the doctors were powerful figures in both the understanding of, and treatment for, the convicted. As I indicated, when there were major inquiries such as that conducted by the Carnarvon Committee in 1863 the evidence of prison doctors like William Guy was heard and treated with respect. Through working in the laboratory of the prison, medical personnel affirmed their status as the professional group who could speak with the authority that this access gave them. At the same time, their views did not diverge from those of the law-makers in Parliament nor the increasingly identifiable and powerful state bureaucracy. Disciplined regulation was the perceived strategy needed to deal with the problem of criminality and potential disorder.

The centralisation of the penal system in 1877 heralded much greater state intervention and co-ordination into institutions in the crucial decades to which Hall and Schwarz refer and which I discussed in Chapters 4 and 5. The observations, research and work of prison doctors such as Quinton, Campbell, Devon, Sutherland and Hamblin-Smith while emphasising different aspects and facets of criminal behaviour were united once more on an ideological terrain which saw the problem of criminality rooted in the individual's body, psyche, temperament or local community. The theories expounded derived from the observation of the criminal in the individualised environment of the prisoner's cell or the doctor's office. They reaffirmed the individualisation



of criminality and the need for professional intervention either into the individual's mind or into particular communities to prevent its contaminating spread. These views did not diverge from the analysis of the medical profession in general or state servants such as the Prison Commissioners who were responsible for the management of the penal system. Indeed the apparent *professionalism and scientific basis of the doctors' studies* gave state intervention and regulation an added disciplinary legitimacy.

After 1945 there was a close relationship between the work of professionals and intellectuals working in, and around the prisons. This relationship was co-ordinated and facilitated by state bureaucrats who provided research funds, access and conference platforms for these groups to meet. This relationship was examined in Chapters 3 and 6 where the research conducted by prison doctors, psychologists and organic intellectuals reflected wider concerns around criminality and disorder that were prevalent at the time. This was particularly relevant to the criminality of women both as creators of criminals in terms of the thesis of maternal deprivation and to the internal constitution of the female criminal herself. The doctors and particularly the psychologists and psychiatrists who observed, probed and tested these women and the theories expounded from their empirical examinations did not simply reflect state concerns about order but reinforced these wider concerns. The unfit and criminal mother was therefore not only the object of theoretical interest for prison doctors and psychiatrists but was also at the centre of the state's concern for the maintenance of order in

the post-war world. Here the inter-relationship becomes complete in a practical sense with the introduction into state institutions of programmes designed to correct female deviance and reconstruct the supine and loving parent. The state's field of activity and its relationship to the criminal in this sense then also varied with gender. While both Catherine MacKinnon and Bob Connell have pointed out that "feminism has no theory of the state" (22), it has nonetheless been possible in this thesis to discern important moments in the state's development in relation to medical discourse and imprisoned women. For example, the research into, and domestic programmes introduced for women in the post-1945 prison system would not have been possible without the direct co-ordination and encouragement of the Home Office state bureaucracy who, above anything else, provided access for such research to take place. Similarly, the surveillance of the women by male professionals strikes a theoretical cord with feminist work in the sociology of occupations and on the state where in the hierarchical division of labour men such as prison doctors occupy the dominant positions of power, authority and decision making (23). These processes allow the state not only to regulate institutions but, according to Connell, help it to constitute "social categories in the gender order" (24). The early twentieth century degenerate woman and the post-1945 unfit mother are two examples in which medical discourse and the state's constitution of gender categories converged on a common theoretical and practical terrain.

This thesis has also illustrated the relationship between medical discourse and more recent but ongoing state concerns around order

and discipline behind the walls. As I indicated in Chapter 5, state servants, politicians and medical personnel have been united in their explanations of disorder in the prisons. The medical figure of the aggressive and manipulative psychopath has loomed large in these deliberations and in the segregation and chemical programmes introduced to deal with what are seen as the recalcitrant minority. Such explanations serve to individualise complex social problems while the contributory elements in social structural and policy arrangements are relegated to the margins. Thus the disciplined regulation of the individual unites medical discourse and the policies and practices of the interventionist state.

Within the contemporary criminal justice system, medical and psychiatric power retains a pivotal role. Throughout the 1980s doctors, psychologists and psychiatrists have continued to propound their views on the nature of criminal and deviant behaviour and to suggest policies to deal with those individuals in these categories. Such views are not limited to the narrow confines of criminal justice. Medical and bio-medical theories also have a place in popular consciousness and have formed the basis for both explaining and offering solutions for a range of behaviour in different social settings. Lord Gisborough's call in May 1982 for the encouragement of the sterilisation of people "least capable of managing their own families" (25); the academic and popular references to XYY men (26); the search for the physical roots of violent behaviour in the brains of convicted criminals (27); and the continuing reference to bio-psychological factors in relation to violence against women (28);

all testify to the continuing power of medical discourse in the construction of what Robert Nye has called "metaphors of pathology produced by medical and scientific experts" (29) which seep and percolate into the public domain and play a dominant role in the discussion of social problems and the responses to them. Within the modern prison system, as I have indicated, bio-medical views of human behaviour are similarly mobilised. The most recent proposals for the building of new generation Panopticon prisons, the introduction of electronic bracelets and the continuing emphasis on the identification and control of small groups of difficult prisoners similarly testify to the power of bio-medical discourse (30).

Contemporary prison medical workers would therefore find much common ground with those who worked in the prisons immediately after Howard's intervention in the mid 1770s. The 200 year gap is bridged not simply by individuals who recognize themselves as prison medical workers (notwithstanding the fact that the majority of contemporary treatment is carried out by outside practitioners) but by the complex and inter-related set of ideologies and practices within which they work. Thus, the issues around discipline, regulation and control and the individualised understanding of deviance that flows from them would provide one common meeting point. Similarly, the appalling conditions in which many prisoners receive their medical treatment in the late 1980s would be recognized by those practising in the 1820s and 1830s, the eligibility of the confined for the receipt of proper medical attention again providing a common terrain that bridges the 200 year gap. They would also recognize

the continuing conflict around their role and the critical questions asked of them by prisoners and their supporters which over the 200 years at times have fractured the medical gaze. Such fracturing has been accomplished through social actions as diverse as ridicule, complaints, pamphlets, assaults and murder. There has been a clear and often uncompromising contestation of medical power.

Reading and analysing the history of the P.M.S. in this way is in a sense a double-edged sword. Sociologically, it allows for the identification of the long history of discipline within which prison medicine has operated together with the continuities and discontinuities in medical and psychiatric practice. Politically, and here I return to Foucault and the quotation which heads this final chapter, writing history in this manner allows for what Michael Donnelly has termed the construction of a "usable past ..... a past or a myth of the past useful in contemporary struggles against the prisons because it debunks the ideological justifications of the other side" (31). In a society where media representations provide, indeed dictate, a short-term historical understanding of social phenomena and events (with the notable exception of monarchical and heritage phenomena) the concept of the history of the present allows for not only an examination of the historical gestation of social phenomena but the kind of political tactics and strategies which might be adopted to deal with processes that have been laid down over decades and centuries rather than weeks and months.

The issue of the use of drugs to control the behaviour of certain

prisoners which I discussed in Chapter 5 is a good example of this. While the controversy surrounding the issue in the late 1970s was given a degree of media coverage it was generally portrayed as one which had sprung up overnight and involved a group of neutral professionals being accused by a deviant group whose activities both within and without the penitentiary had placed them outside of the law. If abuses had occurred then some mechanism for reform would be introduced to alleviate the situation. And yet, as this thesis has shown, the issues around control and regulation through medical practice, are not new but have been deeply embedded in the discourse of institutional medicine since the late eighteenth century. The historical evidence in this work can therefore be seen as a challenge to the view of the benevolence of the medical scientific mission where abuses will be reformed if the profession or the institution or the state is left to its own incorruptable devices. The evidence indicts such a view and raises significant theoretical and political questions about strategies and tactics for changing long-established medical programmes, practices and ideologies. Ultimately, this evidence can be seen as a contribution to Foucault's "usable past", the uncovering and exposure of contemporary strategies which are orientated to the individual will to order rather than the collective need for liberation.

REFERENCES

CHAPTER 1

1. Schrag, P. (1980) Mind Control Marion Boyars p.252.
2. Smith, R. (1984) Prison Health Care British Medical Association.
3. Hinde, R.S.E. (1951) The British Prison System 1773-1950 Gerald Duckworth and Co. Ltd., Howard, D.L. (1960) The English Prisons Butler and Tanner; Elkin, W. (1957) The English Penal System Pelican.
4. Stratton, B. (1973) Who Guards the Guards? PROP.
5. Fitzgerald, M. (1977) Prisoners in Revolt Penguin.
6. Wicker, T. (1975) A Time To Die. The Bodley Head.
7. Fitzgerald, M. op. cit; Boyle, J. (1977) A Sense of Freedom Pan.
8. Fitzgerald, M. op. cit; Pallas, J. and Barber, B. (1980) "From Riot to Revolution" in Platt, T. and Takagi, P. (eds) (1980) Punishment and Penal Discipline Crime and Social Justice pp. 146-54.
9. Davis, A. (1971) If They Come in The Morning New American Library p.37. (emphasis in the original).
10. Cohn-Bendit, D. (1968) Obsolete Communism: The Left Wing Alternative Andre Deutsch; Hall, S. et. al. (1978) Policing the Crisis MacMillan.
11. Hall, S. and Scraton, P. (1981) "Law, Class and Control" in Fitzgerald, M. et. al. (compilers) (1981) Crime and Society: Readings in History and Theory RKP pp. 460-97.
12. Patton, P. (1979) "Of Power and Prisons" in Morris, M. and Patton, P. (1979) (eds) Michel Foucault: Power, Truth and Strategy Ferrall Publishers p.110.
13. Ibid.
14. Simon, J. (1974) "Michel Foucault on Attica: An Interview" in Telos Part 19 Spring 1974 pp. 155-6.
15. Cohen, S. (1985) Visions of Social Control Polity Press p.24.
16. Ignatieff, M. (1978) A Just Measure of Pain MacMillan pp. XI-XII.
17. Ibid, p.XII.
18. Ibid.
19. Cohen, S. op. cit. p.23.
20. Melossi, D. and Pavarini, M. (1981) The Prison and the Factory MacMillan p.1.
21. Cohen, S. op. cit; Ignatieff, M. (1983) "State, Civil Society and Total Institutions: A Critique of Recent Social Histories of Punishment" in Cohen, S. and Scull, A. (eds) (1983) Social Control and the State MacMillan pp.75-105.
22. Gunn, J. et. al. (1978) Medical Aspects of Imprisonment Academic Press; Topp, D.O. (1977) "The Doctor in Prison" in Medicine, Science and The Law pp.261-4; Prewer, R.R. (1974) "The Contribution of Prison Medicine" in Blom-Cooper, L. (ed) (1974) Progress in Penal Reform Oxford University Press pp.116-128; Smith, R. op. cit.
23. Smart, B. (1985) Michel Foucault Tavistock pp.22-5
24. Craib, I. (1984) Modern Social Theory Wheatsheaf
25. Smart, B. (1976) Sociology, Phenomenology and Marxism RKP p.185.
26. Femia, J. (1987) Gramsci's Political Thought Clarendon Press pp.120-1.
27. Calhoun, C. (1982) The Question of Class Struggle Blackwell; Campbell, B. (1984) Wigan Pier Revisited Virago; Willis, P. (1977) Learning to Labour Gower; Gilroy, P. (1987) There Aint No Black in the Union Jack Hutchison.
28. Clarke, J., Hall, S., Jefferson, T. and Roberts, B. (1976) "Subcultures, Cultures and Class" in Hall, S. and Jefferson, T. (eds) 1976) Resistance Through Rituals Hutchinson pp.44-5. (emphasis in the original).



29. Kaye, H. (1984) The British Marxist Historians Polity Press pp.241-2
30. Humphries, S. (1981) Hooligans or Rebels?: An Oral History of Working Class Childhood Blackwell p.239.
31. Piven, F.F. and Cloward, R. (1979) Poor Peoples' Movements Vintage Books pp.20-1.
32. Mort, F. (1987) Dangerous Sexualities RKP pp.5-6.
33. Ibid, p.7.
34. Lukes, S. (ed) (1986) Power Blackwell; Hunt, A. (1978) The Sociological Movement in Law MacMillan; Collins, H. (1984) Marxism and Law Oxford University Press.
35. Sim, J., Scraton, P. and Gordon, P. (1987) "Crime, The State and Critical Analysis" in Scraton, P. (ed) (1987) Law, Order and The Authoritarian State O.U. Press pp.1-70.
36. Garland, D. (1985) "Politics and Policy in Criminological Discourse: A Study in Tendentious Reasoning and Rhetoric" in International Journal of the Sociology of Law Vol. 13 No. 1 February 1985. pp.1-33.
37. Scraton, P. (1985) "The State vs. The People: An Introduction" in Scraton, P. and Thomas P. (eds) (1985) The State vs. The People Blackwell pp.251-66.
38. Hall, S. et. al. op. cit.
39. Gilroy, P. op. cit.
40. Brophy, J. and Smart, C. (eds) (1985) Women in Law RKP.
41. Sykes, G. (1958) The Society of Captives Princeton University Press; Irwin, J. and Cressey, D. (1962) "Thieves, Convicts and the Inmate Culture" in Social Problems Vol. 10 pp.142-55.
42. Cohen, S. and Taylor, L. (1972) Psychological Survival Penguin; Fitzgerald, M. op. cit; Fitzgerald, M. and Sim, J. (1979) British Prisons Blackwell 1st edition; Carlen, P. (1983) Women's Imprisonment RKP; Carlen, P. et. al. (1985) Criminal Women Polity; Box, S. (1982) Power, Crime and Mystification, Tavistock.
43. Ignatieff, M. (1980) "State, Civil Society and Total Institutions; A Critique of Recent Sociological Theories of Punishment. Unpublished draft of paper which appeared in Crime and Society No. 6
44. Mercer, C. (1980) "Revolutions, Reforms or Reformatations? Marxist Discourse on Democracy" in Hunt, A. (ed) (1980) Marxism and Democracy Lawrence and Wishart p.123.
45. Smart, B. op. cit. p.80.
46. Foucault, M. (1977) Discipline and Punish Allen Lane p.250.
47. Smart, B. op. cit. p.64.
48. Ibid, pp. 105-6.
49. Patton, P. op. cit. p.121.
50. Smart, B. op. cit. p.87.
51. Foucault, M. (1983) "Power, Sovereignty and Discipline" in Held, D. et. al. (eds) (1983) States and Societies Martin Robertson p.310.
52. Smart, B. op. cit. p.132.
53. Ibid, p.135.
54. Ibid.
55. Cohen, S. op. cit. p.10.
56. Ibid, p.3.
57. Ibid, p.26.
58. Ibid.
59. Ibid, pp.194-5.
60. Ibid, pp.195-6.

CHAPTER 2

1. Smith, R. (1983) "Organisation of Prison Medical Services" in British Medical Journal Vol. 287 17th December 1983 p.1870.
2. Civil Service Year Book 1986 HMSO col. 429.
3. Home Office, (1979) "The Prison Medical Service: England and Wales" in Inquiry into the U.K. Prison Services Vol II Evidence by the Home Office, the Scottish Home and Health Department and the Northern Ireland Office. HMSO p.214.
4. Prison Service News Vol. 1 No. 2, February, 1983.
5. Smith, R. op. cit. p.1867.
6. Home Office, (1977) Prisons and the Prisoner HMSO paragraph 217.
7. Civil Service Year Book op. cit. col. 429.
8. Home Office op. cit p.214.
9. Owen, T. (1979) Medical Treatment in Prisons. Unpublished Paper.
10. House of Commons Social Services Committee, (1986) Third Report Session 1985-86 Prison Medical Service Vol. 1 Report Together with the Proceedings of the Committee, paragraph 17.
11. Ibid.
12. Ibid, paragraph 103.
13. Ibid, paragraph 102.
14. Ibid.
15. Home Office, (1985a) Report on the Work of the Prison Department 1984/5 HMSO p.125.
16. National Association for the Care and Resettlement of Offenders, (1986) The Prison Medical Service NACRO p.2.
17. Greater London Council Women's Committee, (1986) Breaking the Silence London Strategic Policy Unit p.164.
18. Senn, Dr. R.C., Ingrey, (1978) "Prison Medicine" in Medical Services for Prisoners: Report of a Day Conference held by the Howard League for Penal Reform. King's Fund Centre p.3.
19. Smith, R. op. cit. p.1867.
20. Home Office, (1981a) H.M. Prison Gloucester Report of H.M. Chief Inspector of Prisons. Home Office p.21.
21. Home Office, (1981b) H.M. Prison Durham Report of H.M. Chief Inspector of Prisons. Home Office p.25.
22. Home Office, (1985b) H.M. Prison Norwich Report of H.M. Chief Inspector of Prisons. Home Office p.15.
23. Ibid, p.15.
24. House of Commons Social Services Committee op. cit, paragraph 26.
25. See the reports by the Chief Inspector of Prisons on Gloucester and Durham op. cit.
26. Lee, B. (1983) "Free the Prison Doctors Now" in World Medicine 6th August 1983 pp.20-1.
27. National Association for the Care and Resettlement of Offenders op. cit. p.10.
28. Home Office, (1985a) op. cit. p.122.
29. Figures calculated from Reports on the Work of the Prison Department 1970-1980; Prison Statistics England and Wales 1970-1980 HMSO.
30. Home Office, (1982a) Prison Statistics England and Wales 1982 HMSO p.142.
31. Home Office, (1982b) Report of Her Majesty's Chief Inspector of Prisons 1982 HMSO p.20.
32. Ibid.

33. Prison Reform Trust, (1984) Beyond Restraint Prison Reform Trust p.2 (emphasis in the original).
34. Home Office, (1982b) op. cit. p.20.
35. Prison Reform Trust op. cit. p.2.
36. Home Office, (1982b) op. cit. pp.20-1.
37. Ibid, p.21.
38. Ibid, p.20-1.
39. Prison Reform Trust op. cit. p.3.
40. Ibid.
41. Ibid, p.5.
42. Home Office, (1981c) H.M. Prison Birmingham, Report of Her Majesty's Chief Inspector of Prisons Home Office p.25.
43. Ibid.
44. Ibid.
45. Ibid.
46. Ibid.
47. Home Office, (1982b) op. cit. p.21.
48. Home Office, (1981b) op. cit. p.25.
49. Home Office, (1982c) H.M. Prison Nottingham, Report of Her Majesty's Chief Inspector of Prisons Home Office p.5.
50. Ibid.
51. Home Office, (1983) H.M. Remand Centre Ashford. Report of H.M. Chief Inspector of Prisons. Home Office p.10.
52. Prison Reform Trust op. cit. p.2.
53. House of Commons Social Services Committee op. cit. paragraph 86.
54. Ibid.
55. Home Office, (1979) op. cit. pp. 213-14; Home Office (undated) The Prison and Borstal Nursing Service. The Home Office.
56. Home Office (1985a) op. cit. p.68.
57. House of Commons Social Services Committee op. cit. paragraph 86.
58. Ibid, paragraph 89.
59. Home Office, (1979) op. cit. p.213
60. Cited in World in Action, (1982) Prisoners' Medicine Transcript No. p.568/603 19th July, 1982.
61. Owen T. op. cit. p.10.
62. King, R. and Morgan, R. (1980) The Future of the Prison System Gower p.131.
63. Strank, R.A. (1983) "Nursing Care in Prison" in Association of Members of Boards of Visitors Quarterly No. 9 April 1983 p.8.
64. Home Office, (1985a) op. cit. pp.68-9.
65. House of Commons Social Services Committee op. cit, paragraph 87.
66. Home Office, (1985a) op. cit. pp.68-9.
67. House of Commons Social Services Committee op. cit. paragraph 30.
68. Ibid.
69. Ibid, paragraph 31.
70. New Statesman 5th July 1985.
71. Ibid.
72. House of Commons Social Services Committee op. cit. paragraph 96.
73. Maguire, M., Vagg, J. and Morgan, R. (eds) (1985) Accountability and Prisons. Tavistock p.7.
74. Plotnikoff, J. (1986) Prison Rules: A Working Guide The Prison Reform Trust p.9.
75. Maguire, M. et. al. op. cit. p.7.
76. Prison Rules 1964 as amended by the Prison (Amendment) Rules of 1968, 1971, 1972, 1974, 1976 and 1981 p.8
77. Prison Standing Orders June 1981 Section 13 pp.241-2.

78. Prison Rules op. cit. p.9.
79. Ibid.
80. Prison Standing Orders op. cit. p.245.
81. Senn, Dr. R.C. Ingrey op. cit. p.7.
82. Circular Instruction No. 20 1977 Home Office.
83. Prison Statistics England and Wales 1981 HMSO p.138.
84. Prison Statistics England and Wales 1984 HMSO p.140.
85. Ibid, Table 10.2.
86. Ibid.
87. Bowden, T. (1978) "Ethical Aspects of the Role of the Medical Officers in Prison" in Medical Services for Prisoners op. cit. p. 38.
88. Prison Standing Orders op. cit. p.184.
89. Ibid.
90. Circular Instruction No. 20/1977 Home Office.
91. Ibid.
92. Ibid.
93. Circular Instruction 29/1981 Home Office.
94. Ibid.
95. Senn, Dr. R.C. Ingrey op. cit. p.6.
96. Home Office, (1985a) Table 7.
97. King, R. and Morgan, R. (1976) A Taste of Prison. R.K.P. pp. 30-1.
98. Ibid.
99. MacKeith, J.A.C. (1978) "Practical Constraints of the Work of the Prison Medical Officer" in Medical Services for Prisoners op. cit. p.54.
100. West, D.J. and Bearcroft, J.S. (1960) "The Choice of Bail or Custody for Offenders Remanded for a Psychiatric Report" in International Journal of Social Psychiatry Vol. 6. No. 34. pp.34-50.
101. Sparks, R.F. (1966) "The Decision to Remand for Mental Examination" in British Journal of Criminology Vol. 6. pp. 6-26.
102. Ibid, p.12.
103. Gibbens, T.C.N., Soothill, K.L. and Pope, P.J. (1977) Medical Remands in the Criminal Court. Oxford University Press/Institute of Psychiatry Maudsley Monographs No. 25.
104. Ibid, p.93.
105. Ibid.
106. Candy, J. (1985) "The Relationship of the Prison Medical Service to the National Health Service" in Prison Reform Trust (1985) Submission to the House of Commons Social Services Committee of Inquiry into the Prison Medical Service. Prison Reform Trust p.23.
107. Whitehead, T. (1983) Mental Illness and the Law Basil Blackwell p.77
108. Ibid, p.79.
109. Calculated from Prison Statistics England and Wales 1980 Tables 1.4 and 10.4.
110. Ibid.
111. Whitehead, T. op. cit. p.81.
112. Home Office, (1985A) op. cit. Table 3.
113. Calculated from Prison Statistics England and Wales 1980 Tables 1.4 and 10.4.
114. The Royal College of Psychiatrists (No Date) Evidence to the Inquiry into the United Kingdom Prison Services Document EF 73/78 p.6.
115. Ibid.
116. Ibid.

117. Kemp, D. (1983) "Prisoners and the Mental Health Act" in Prison Service Journal July 1983 p.6.
118. Ibid.
119. Home Office (No Date) Inside Hospital Care: The Prison Hospital Officer. The Home Office.
120. Ibid.
121. Prison Standing Orders op. cit. paragraph 225.
122. Ibid.
123. Ibid.
124. Ibid.
125. Home Office, (No Date) The Prison and Borstal Nursing Service. The Home Office.
126. Ibid.
127. Prison Standing Orders op. cit. p.243.
128. Ibid.
129. Ibid.
130. Ibid.

CHAPTER 3

1. Lloyd, R. and Williamson, S. (1968) Born to Trouble Cassirer pp.72-3.
2. Carlen, P. (1986) "Psychiatry in Prisons: promises, premises, practices and politics" in Miller, P. and Rose, N. (eds) (1986) The Power of Psychiatry Polity Press pp.265-6 (emphasis in the original).
3. Garland, D. (1985) Punishment and Welfare Gower p.262.
4. Cohen, S. and Taylor, L. (1978) Prison Secrets. RAP/NCCL.
5. Mathiesen, T. (1974) The Politics of Abolition. Martin Robertson.
6. Leigh, D. (1980) The Frontiers of Secrecy Junction Books;
7. Ponting, C. (1986) Whitehall: Tragedy and Farce. Sphere.
8. Krohn, M. (1986) "The Web of Conformity: A Network Approach to the Explanation of Deviant Behaviour" in Social Problems Vol. 33 No. 6 December 1986 p.563.
9. Smart, B. (1976) Sociology, Phenomenology and Marxism. Routledge and Kegan Paul p.176.
10. Ibid.
11. Hall, S., Critcher, C. Jefferson, T., Clarke, J., and Roberts, B., (1978) Policing the Crisis MacMillan., Morgan, K. (1985) Labour in Power 1945-51 Oxford University Press; Panitch, L. (1986) Working Class Politics in Crisis Verso.
12. Hall, S. et. al. op. cit. p.228.
13. Morgan, K. op. cit. p.41.
14. Doyal, L. and Pennell, I. (1979) The Political Economy of Health Pluto p.180.
15. Ibid, p.182.
16. Morgan, K. op. cit. p.158.
17. Ibid, p.162.
18. Taylor, I. (1981) Law and Order: Arguments for Socialism MacMillan p.74.
19. Gilroy, P. (1987) There Aint No Black in the Union Jack. Hutchinson.
20. The Times 13th August 1947.
21. The Times 23rd January 1948.
22. See in particular Pearson, G. (1983) Hooligan: A History of Respectable Fears MacMillan.
23. British Medical Journal (hereafter BMJ) 14th December 1946 p.909.
24. Ibid.
25. Ibid, p.910.
26. Ibid.
27. The Times 5th July 1947.
28. Ibid.
29. The Times 5th August, 1949.
30. BMJ 24th September 1949.
31. BMJ 15th October 1949.
32. Rutter, M. (1972) Maternal Deprivation Re-Assessed Penguin
33. Taylor, I. op. cit.; Wilson, E. (1977) Only Halfway to Paradise Tavistock. The WHO published other documents at this time which purported to analyse contemporary issues scientifically. In January 1954, for example, it published a study entitled, The African Mind in Health and Disease: A Study in Ethnopsychiatry. The author, Dr. Carothers argued that African behaviour resembled that of a "leucotomised European psychopath" (The Lancet 26th June 1954; 1350). The evidence for this was based on 33 personal and

subjective anecdotes which depicted "unreliable behaviour in Africans" including the fact that he had put his shoes out "to be mended in my shopping basket the night before so that I shall remember to take them to the cobbler the next day; the houseboy takes them out, cleans them and puts them elsewhere, though he might assume that they had been put in the basket for some purpose" (Ibid).

33. Taylor, I. op. cit. p.71.
34. BMJ 11th March 1950.
35. Ibid.
36. The Lancet 26th May 1951 p.1166.
37. BMJ 5th August, 1950. p.311.
38. The Times 5th August 1950.
39. BMJ 5th August 1950. p.315.
40. BMJ 2nd June 1951 p.1260.
41. Ibid, p.1261.
42. BMJ 5th August 1950. p.335.
43. BMJ 7th October 1950. p.797.
44. Jones, A.E. (1945) Juvenile Delinquency and the Law Penguin p.29.
45. BMJ 3rd February 1945. p.157.
46. Taylor, I. op. cit. p.56. (emphasis in the original).
47. Mannheim, H. (1946) Criminal Justice and Social Reconstruction R.K.P. p.2.
48. Ibid, pp.23-4.
49. Ibid, p.22. While the Department Committee appointed by the Board of Control which reported in 1934 had recommended sterilisation in certain cases, Chuter Ede, the Home Secretary in the post-war Labour government refused to introduce legislation to legalise it. (Hansard 16th March 1950 col. 1226).
50. Ibid, p.237.
51. Ibid, pp.246-7.
52. Jones, H. (1956) Crime and the Penal System University Tutorial Press p.272.
53. Ibid, p.275.
54. Ibid.
55. Ibid, p.279.
56. Ibid, p.277.
57. BMJ 2nd June 1951 p.1260.
58. Ibid.
59. Rutherford, A. (1983) Prisons and the Process of Justice Heinemann; Ryan, M. (1983) The Politics of Penal Reform Longmans.
60. Morgan, K. op. cit. p.56.
61. The Times 1st January 1953.
62. Thomas, J.E. (1972) The English Prison Officer since 1850 R.K.P.
63. Ibid.
64. Hansard 26th November 1945 col. 1037.
65. Report of the Commissioners of Prisons and Directors of Convict Prisons for the year 1946 (hereafter RCPDCP) p.14.
66. Ibid.
67. Ibid.
68. Ibid, p.15.
69. RCPDCP 1947, p.12.
70. Ibid, p.72.
71. RCPDCP 1950 p.14
72. Clarke, J., Hall, S., Jefferson, T., and Roberts, B., (1976) "Subcultures, Cultures and Class" in Hall, S., and Jefferson, T. (eds) (1976) Resistance Through Rituals Hutchinson p.45 (emphasis in the original).

73. Reid, P. (1984) Colditz: The Full Story MacMillan;  
Neillis, M., and Hale, C. (1982) The Prison Film,  
Radical Alternatives to Prison.
74. Cited in Thomas, J.E. op. cit. p.185.
75. Hansard 18th July 1946 col. 1370.
76. Hansard 20th December 1945 col.1524.
77. RCPDCP 1948 p.33.
78. RCPDCP 1950 p.44.
79. The Lancet 20th March 1948 p.460.
80. The Times 22nd February 1950.
81. The Times 4th May 1954.
82. The Times 28th January 1954.
83. The Times 27th May; 18th June 1954.
84. The Times 30th January 1952.
85. The Times 15th October 1953.
86. Elkin, W. (1957) The English Penal System Penguin p.187.
87. The Lancet 25th August 1945 p.251.
88. RCPDCP 1945 p.51.
89. Fox, L. (1952) The English Prison and Borstal Systems R.K.P.  
pp.154-5.
90. Ibid, p.239.
91. Ibid.
92. Ibid, p.241.
93. Ibid.
94. Ibid, p.242.
95. RCPDCP 1945 p.52.
96. RCPDCP 1947 p.61.
97. Ibid.
98. Showalter, E. (1987) The Female Malady Virago pp.205-6.
99. Ibid, pp.206-7.
100. Report of the Commissioners of Prisons 1960 (hereafter RCP) p.74.
101. RCPDCP 1946 p.62.
102. Ibid.
103. Hansard 18th April 1946 cols 2867-2868.
104. RCPDCP 1949 p.67.
105. Ibid, p.68.
106. BMJ 8th September 1951 p.594.
107. Cited in Elkin, W. op. cit. p.18.
108. Ibid p.19.
109. Hansard 7th February 1946 cols 1859-1860.
110. Ibid.
111. Hansard 28th March 1949 cols 87-8.
112. RCP 1953 p.101.
113. Ibid, p.139.
114. RCP 1954 p.138.
115. Calder, W. (1955) "The Sexual Offender: A Prison Medical Officer's  
Viewpoint" in British Journal of Delinquency July 1955 pp.28-30.
116. Ibid, pp.32-9.
117. Ibid, p.40.
118. Wildeblood, P. (1955) Against the Law Penguin pp.103-4.
119. Gramsci, A. (1985) Selections From Cultural Writings Lawrence  
and Wishart pp.132-33.
120. Home Office Notice 141/1946 The New Post of Medical Advisor  
to the Home Office.
121. Ibid.
122. Ibid.



123. The Times 3rd January 1951.
124. BMJ 16th February 1963 p.484.
125. The Times 12th March 1946.
126. HMSO (1950) Prisons and Borstals HMSO p.11 (emphasis in the original).
127. Ibid.
128. BMJ 22nd November 1947.
129. Ibid.
130. Gunn, J., Robertson, G., Dell, S., and Way, C. (1978) Medical Aspects of Imprisonment Academic Press p.24.
131. Ibid.
132. RCPDCP 1949 p.69.
133. Ibid.
134. Ibid.
135. The Times 23rd October 1953.
136. Hansard 2nd December 1949 col. 1497.
137. Ibid., col. 1483.
138. RCPDCP 1949 p.120.
139. Ibid.
140. RCPDCP 1950 p.78.
141. Ibid., p.113.
142. BMJ 12 August 1950 p.414.
143. RCPDCP 1949 p.122.
144. Ibid.
145. Ibid., p.92.
146. "Psychiatry in Prisons and Corrective Institutions" in Proceedings of the Royal Society of Medicine Vol. XLVII 1954 p.223.
147. Ibid., p.224.
148. Parker, T., and Allerton, R. (1962) The Courage of His Convictions Hutchinson pp.138-9.
149. Fox, L. op. cit. p.247.
150. Ibid., pp.247-8.
151. The Lancet 18th December 1954 p.1277.
152. Lloyd, R. and Williamson, S. op. cit. p.82.
153. Ibid., p.144.
154. Ibid. p.145.
155. Showalter, E. op. cit. p.253.
156. Ibid., p.209.
157. Ibid.
158. Ibid., p.210.
159. Lloyd, R., and Williamson, S. op. cit. p.145-6.
160. RCP 1961 p.68.
161. Probyn, W. (1977) Angel Face: The Making of a Criminal Allen and Unwin p.43.
162. Ibid., p.53.
163. Lloyd, R., and Williamson, S. op. cit. p.82.
164. Probyn, W. op. cit. p.53.
165. RCP 1958 p. 140.
166. Ibid.
167. RCP 1959 p 143.
168. Ibid., p.141.
169. The Lancet 25th September 1954 p.637.
170. RCP 1958 p.103.
171. Ibid., p.138.
172. RCP 1962 p.86.
173. The Lancet 23rd December 1961 p.1409.
174. Thomas, J.E. op. cit. p.189.

175. The Times 30th May 1952.
176. Ibid.
177. Thomas, E. (1965) The Psychologist in the Prison Service CP Report 5th February 1965 p.5.
178. Ibid.
179. Webb, S., and Webb, B. (1922) English Prisons Under Local Government Longmans Green and Co. p.235.
180. Michael, J. (1982) The Politics of Secrecy Penguin; Leigh, D. op. cit.
181. Hobhouse, S. and Brockway, F. (1922), English Prisons Today Frank Cass and Co. Ltd. p.VI.
182. Ibid, p.270.
183. Ibid, p.146.
184. Ibid.
185. Prison Medical Reform Council (1943a) Prison Medical Service Prison Medical Reform Council p.15.
186. Ibid, p.14.
187. Ibid, pp.14-15.
188. Prison Medical Reform Council (1943b) Prisoners' Circle PMRC p.32.
189. Prison Medical Reform Council (1943a) op. cit. Foreword.
190. Prison Medical Reform Council (1943a) op. cit. pp.3-4.
191. Ibid, p.13.
192. Prison Medical Reform Council (1943c) Prison For Women: Some Accounts of Life in Holloway Prison Medical Reform Council pp.21-2.
193. Prison Medical Reform Council (1944) Prisoners Medical Charter Prison Medical Reform Council p.3.
194. Prison Medical Reform Council (1945) The Case of Prisoner Alpha Prison Medical Reform Council p.4.
195. Ibid, p.10.
196. Prison Reform Council (1962) Inside Story Prison Reform Council p.1.
197. Ibid, p.6.
198. Ibid, p.8.
199. The Lancet 31st July 1948 p.191.
200. Baker, P. (1962) Time Out of Life The Quality Book Club pp.130-52.
201. Ibid, p.131.
202. Ibid, p.138.
203. The Lancet 4th August 1945 p.145.
204. Ibid, p.146.
205. The Lancet 8th February 1947 p.219.
206. Ibid.
207. The Lancet 31st January 1948 p.197.
208. The Lancet 26th November 1949 p.1016.
209. Poulantzas, N. op. cit. p.151.
210. The Times 10th October 1953.
211. Ibid.
212. BMJ 24th April 1954 p.981.
213. Ibid.
214. Ibid.
215. The Lancet 4th June 1955 p.1159.
216. Ibid, p.1160.
217. Ibid.
218. The Lancet 20th September 1958 pp.625-6.
219. Ibid, p.626.
220. The Lancet 11th October 1958 p.783.
221. The Lancet 7th January 1961 p.37.
222. Ibid.
223. The Lancet 21st April 1956 pp.96-8.

224. Ibid.
225. Marcus, B. (1958) "A Dimensional Study of a Prison Population" Psychologists Monograph No. 2 Office of Chief Psychologist Prison Commission London SW1 December 1958 pp.4-5.
226. BMJ Vol. 1. 1951 p.1243.
227. Ibid.
228. RCP 1954 pp.101-2.
229. Ibid.
230. RCP 1956 p.115.
231. Ibid.
232. RCP 1952 pp.106-7.
233. Ibid, p.107.
234. The Lancet 5th December 1953 pp.126-7.
235. RCP 1956 p.1.
236. Ibid.
237. RCP 1957 p.2.
238. RCP 1958 p.2.
239. The Lancet 27th July 1957 p.200.
240. BMJ 8th November 1958 p.1154.
241. Ibid.
242. Ibid, p.1169.
243. Ibid.
244. BMJ 12th August 1961 p.436.
245. Ibid, p.437.
246. Ibid.
247. Ibid.
248. RCP 1953 p.140.
249. Ibid.
250. RCP 1951 pp90-3.
251. RCP 1955 p.148.
252. RCP 1957 p.24.
253. RCPOCP 1950 pp.81-5.
254. Fox, L. (1960) "The Prison Service Since the War" in Prison Service Journal Vol. 1 Part 1 July 1960 pp.4-14.
255. RCP 1953 op. cit. p.6.
256. BMJ 14th March 1953 pp.626-7.
257. The Lancet 13th February 1954 p.363.
258. The Lancet 8th May 1954 p.986.
259. The Lancet 14th May 1955 p.1021.
260. Taken from RCP 1956-1960.
261. The Lancet 23rd March 1957 p.642.
262. The Lancet 3rd May 1958 p.970.
263. Ibid, p.971.
264. Ibid, p.970.
265. The Lancet 13th September 1958 p.565.
266. The Lancet 5th September 1959 p.1016.
267. RCP 1954 p.137.
268. Ibid.
269. RCP 1955 p.149.
270. Ibid.
271. RCP 1956 p.166.
272. RCP 1959 p.24.
273. Ibid.
274. RCP 1957 p.32.
275. Linebaugh, P. (1977) "The Tyburn Riot Against the Surgeons" in Hay, D., et. al. (eds) (1977) Albion's Fatal Tree Peregrine pp.65-118.

276. Morris, T., and Morris, P. (1963) Pentonville R.K.P.
277. Morris, T. et. al. (1961) Unpublished Report on the Prison Community Research Project 1958-1961 p.13 situated in H.M. Prison Library, Wakefield.
278. Ibid, p.14.
279. Ibid, p.18.
280. Ibid.
281. Vick, G.R. (1958) Allegations of Ill Treatment of Prisoners in H.M. Prison Liverpool HMSO p.13.
282. RCP 1951 p.86.
283. RCP 1952 p.146.
284. RCP 1954 p.141.
285. RCP 1956 p.115.
286. Ibid.
287. RCP 1958 p.139.
288. RCP 1954 p.102.
289. The Lancet 28th August 1954 p.446.
290. The Lancet 25th December 1954 p.1334.
291. BMJ 6th September 1958 p.628.
292. RCP 1958 pp.104-5.
293. Ibid.
294. Report of the Work of the Prison Department 1963 p.9 (hereafter RWPDP).
295. RCP 1952 p.107.
296. Ibid, p.102.
297. RCP 1953 p.93.
298. RCP 1958 p.95.
299. RCP 1951 p.82.
300. RCP 1954 p.99.
301. Ibid, p.140.
302. RCP 1961 p.58.
303. Cited in The Lancet 15th October 1955 pp.830-1.
304. The Lancet 28th April 1956 p.574.
305. Ibid.
306. The Lancet 29th May 1954 p.1136.
307. The Lancet 16th March 1957 p.583.
308. Daily Telegraph 19th February 1959.
309. The Lancet 4th April 1959 p.734.
310. Ibid.
311. The Lancet 23rd May 1959 p.1100.
312. Ibid.
313. The Lancet 7th October 1961 p.810.
314. Ibid.
315. Ibid, pp.810-11.
316. The Lancet 11th November 1961 p.1097.
317. The Lancet 9th December 1961 p.1309.
318. The Lancet 23rd December 1961 p.1409.
319. The Lancet 7th April 1962 p.745.
320. Ibid.
321. The Lancet 23rd February 1963 pp.430-1.
322. The Lancet 16th March 1963 p.605.
323. The Lancet 13th April 1963 p.1029
324. The Lancet 27th April 1963 p.948.
325. The Lancet 31st December 1960 p.1455.
326. The Lancet 8th May 1954 p.969.
327. The Lancet 11th February 1961 p.346.
328. BMJ 13th May 1961 p.1393.
329. The Lancet 16th February 1963 p.396.

- 330. Ibid.
- 331. Ibid.
- 332. BMJ 2nd December 1961 p.1505.
- 333. Snell, H. (1959) "The Prison Medical Service" in Howard Journal Vol. 10. No. 2 1959 pp.84-5.
- 334. Wootton B. (1963) "The Law, the Doctor and the Deviant" in BMJ 27th July 1963 p.201.
- 335. Ibid, p.200.
- 336. Ibid.
- 337. Ibid, p.201.
- 338. Treacher, A., and Baruch, G. (1981) "Towards a Critical History of the Psychiatric Profession" in Ingleby, D. (ed) (1981) Critical Psychiatry Penguin p.144-57.
- 339. BMJ 23rd March 1963 p.768.
- 340. The Lancet 12th November 1960 p.1073.
- 341. The Lancet 15th April 1959 p.840.
- 342. Ibid, p.841.
- 343. Ibid.
- 344. The Lancet 1st September 1962 p.440.
- 345. RCP 1961 p.86.
- 346. RCP 1962 p.73.
- 347. RCP 1961 p.18.
- 348. Ibid, p.20.
- 349. Ibid, p.52.
- 350. RCP 1961 p.13.
- 351. RCP 1960 p.15.
- 352. RCP 1962 p.12.
- 353. BMJ 17th November 1962 p.1337.
- 354. The Lancet 16th February 1963.
- 355. Corrigan, P., and Sayer, D. (1985) The Great Arch Blackwell p.197.
- 356. Ibid, P.6; Sim, J. (1986) "Watching the Prison Wheels Grind: The 1985 Report of H.M. Chief Inspector of Prisons" in The Abolitionist No. 21 (1986 No. 1) p.8.
- 357. The Medical Directory (1972) 128th Annual Issue Part 1 Churchill and Livingstone pp.1145.
- 358. The Medical Directory(1972) 128th Annual Issue Part 2 Churchill and Livingstone pp.2283.
- 359. RWPD 1964 pp.2-3.
- 360. BMJ 2nd May 1964 p.1134.
- 361. The Lancet 2nd May 1964 p.968

CHAPTER 4

1. Figlio, K. (1978) "Chlorosis and Chronic Disease in 19th Century Britain: The Social Construction of Somatic Illness in a Capitalist Society" in International Journal of Health Services Vol. 8 No. 4 1978 p.611.
2. Rosen, G. (1973) "Health, History and the Social Sciences" in Social Science and Medicine No. 7 1973 p.236.
3. Cousins, M., and Hussain, A. (1984) Michael Foucault MacMillan p.151.
4. Ibid, p.146.
5. Cited in Rabinow, P. (ed) (1984) The Foucault Reader Peregrine pp. 283-4.
6. Smart, B. (1985) Michael Foucault Tavistock p.93.
7. Cited in Rainbow, P. op. cit. p.204.
8. Ibid, p.224.
9. Griffiths, A. (1905) Fifty Years of Public Service Cassell and Company p.205.
10. Ignatieff, M. (1933) "State, Civil Society and Total Institutions: A Critique of Recent Social Histories of Imprisonment" in Cohen, S. and Scull, A. (eds) (1933) Social Control and the State Martin Robertson p.95.
11. See, for example, Garland, D. (1985) Punishment and Welfare Gower.
12. McConville, S. (1981) A History of English Prison Administration Vol. 1 1750-1877 R.K.P. pp.76-7.
13. Ibid, p.15.
14. Ignatieff, M. (1978) A Just Measure of Pain MacMillan p.52.
15. Ibid, p.60.
16. Ibid, pp.61-2.
17. Aikin, J. (1772) A View of the Character and Public Services of the Late John Howard J. Johnson pp.79-81 (emphasis in the original).
18. Good, J.M. (1795) A Dissertation on the Diseases of Prisons and Workhouses C. Dilly p.113-19.
19. Ibid, p.133.
20. Ibid, p.23.
21. Ibid, p.26.
22. Ibid, pp.106-7.
23. Ignatieff, M. op. cit. p.59.
24. Lettson, J. (1786) Memoirs of John Fothergill C. Dilly pp.126-7.
25. Ibid, p.123.
26. Ibid, pp.133-7 (emphasis in the original).
27. Fox, R. Hingston (1919) John Fothergill and His Friends: Chapters in 18th Century Life. MacMillan and Co. pp.105-6.
28. Guy, W. (1882) John Howard's Winter's Journey. Thos. De La Rue and Co.
29. Ibid, p.13.
30. McConville, S. op. cit. p.85.
31. Philips, D. (1980) "A New Engine of Power and Authority: The Institutionalisation of Law Enforcement in England" in Gatrell, V. et. al. (eds) 1980 Crime and the Law Europa pp.155-189.
32. Waddington, I. (1977) "General Practitioners and Consultants in Early Nineteenth Century England: The Sociology of an Intra-Professional Conflict" in Woodward, J., and Richards, D. (eds) (1977) Health Care and Popular Medicine in Nineteenth Century England Croom Helm.

33. Ignatieff, M. op. cit. p.100.
34. Ibid, p.101.
35. Ibid.
36. Cited in Whiting, J.S. (1975) Prison Reform in Gloucestershire 1776-1820 Philmore and Co. p.42.
37. Ibid, pp.42-3.
38. Ibid, p.44.
39. McConville, S. op. cit. p.130.
40. Rules and Regulations of the General Penitentiary at Millbank. Ordered by the House of Commons to be printed on 4th March 1817. University of Cambridge, Institute of Criminology. Blue Books pp.11-12.
41. Ignatieff, M. op. cit. p.171.
42. Griffiths, A. (1875) Memorials of Millbank and Chapters in Prison History 2 volumes. Henry S. King, Vol. 1, p.197.
43. McConville, S. op. cit. p. 142.
44. Parliamentary Papers Session 1823 - 4 Vol. 10 p.3. (Hereafter PP) Irish University Press.
45. The Lancet Vol. 1 1823-4 p.99.
46. Latham, P. (1825) An Account of the Diseases Lately Prevalent at the General Penitentiary Thomas and George Underwood p.14.
47. P.P. Session 1823-4 Vol. 1 p.11.
48. Parliamentary Debates Vol. 28 1814 cols. 93-5, 116-21, 826-7, 746-7 (hereafter PD).
49. Ibid, col. 839-42.
50. Ibid, col. 258.
51. Ibid, col. 483-4.
52. Gurney, J.M. (1819) Notes on a Visit Made to Some of the Prisons in Scotland and the North of England. Archibald Constable and Co.
53. Ibid, p.112.
54. Ibid, pp.112-3.
55. Cited in Henriques, U. (1979) Before The Welfare State Longmans pp. 160-1.
56. Cited in Fraser, D. (1973) The Evolution of the British Welfare State MacMillan p.60.
57. Ibid, pp.82-3.
58. The Lancet 1836 Vol. 2 pp.338-9.
59. Forbes, T.R. (1977) "A Mortality Record for Cold Bath Fields" in Bulletin of New York Academy of Medicine Vol. 53. No. 7 September 1977 pp.668-9.
60. Parliamentary Debates Vol. 33 1816 col. 545.
61. The Lancet 26th July 1828 p.534.
62. The Lancet 1828-9 Vol. 2 p.754.
63. Cited in Ward, T. (1984) "Coroners, Police and Deaths in Custody in England: A Historical Perspective" in Rolston, B. (ed) (1984) The State of Information in 1984: Working Papers in European Criminology No. 6. European Group for the Study of Deviance and Social Control p.191.
64. The Lancet 1830-1 Vol. 2. p.144.
65. Ibid.
66. Atholl, J. (1953) Prison on the Moor John Long p.35.
67. Ibid, p.36.
68. Parliamentary Reports Vol. 3 1812 p.145 (hereafter PR).

69. Ibid, p.418.
70. PD 1822 Vol. 6 col. 862.
71. Ibid, col. 1078.
72. Ibid, col. 1079.
73. Ibid, col. 14-15.
74. Ibid, col. 15.
75. First Report of the Inspectors of Prisons 1836 p.90.
76. Second Report of the Inspectors of Prisons 1837 p.38.
77. The Lancet 1836-7 Vol. 2 p.169.
78. Ibid.
79. Corrigan, P. (1977) State Formation and Moral Regulation in Nineteenth Century Britain: Sociological Investigations unpublished Ph.D. Thesis University of Durham p.324.
80. The Lancet 1837/8 Vol. 2 p.779.
81. Ibid, p.780.
82. Ibid, pp.780-1.
83. The Lancet 1839/40 Vol. 2 p.530.
84. Ibid, p.428.
85. The Lancet 1831/2 Vol. 2 pp.505-6.
86. Godfrey, C. (1979) "The Chartist Prisoners 1839-41" in Int. Review of Social History Vol. XXIV 1979 Part 2 p.217.
87. Ibid, pp.217-18.
88. Seventh Report of the Inspectors of Prisons 1842 p.103.
89. Ibid, p.137.
90. Priestley, P. (1985) Victorian Prison Lives Methuen p.151.
91. Ibid, p.150.
92. Ibid, p.157.
93. Ibid, p.162.
94. Ibid, p.158.
95. The British and Foreign Medico - Chirurgical Review Vol. 11 July - October 1848 p.413.
96. Ibid, p.415.
97. Ibid, p.421.
98. The Lancet 1843 Vol. 2 p.390. (emphasis in the original).
99. The Lancet 1858 Vol. 2 p.285.
100. McConville, S. op. cit. p.398.
101. Ibid.
102. P.R.O. Prison Comm. 2 - 293 Governors Journal H.M. Prison Bedford 1852-59. (Kew Gardens).
103. Ibid.
104. BMJ 5th October 1861 p.365.
105. Ibid.
106. Ibid.
107. The Lancet 1854 Vol. 2 p.107.
108. Cited in Priestley, P. op. cit. p.130.
109. Ibid, pp.211-12.
110. Ibid, p.213.
111. The Lancet 1855 Vol. 2 p.131.
112. Ibid, p.132.
113. The Lancet 1842/3 Vol. 2 p.305.
114. The Lancet 1845 Vol. 1 p.275.
115. Cited in Report of the Inspectors of Millbank Prison for the Year 1849 (Blue Book, Institute of Criminology, Cambridge) p.12.
116. Ibid.
117. Baly, W. (1845) "On the Mortality in Prisons and the Diseases Most Frequently Fated to Prisoners" in Medico - Chirurgical Transactions Vol. XXVIII Longman, Brown, Green and Longman p.234.



118. Ibid.
119. Further Papers with Reference to the Inquiry Respecting the Treatment of Prisoners in the House of Correction Knutsford 1843, (Blue Book, Institute of Criminology, Cambridge) p.5.
120. P.R.O. P. Com. 2354 Portland Governors' Journal Nov. 24th 1848 - August 9th 1851. (Kew Gardens).
121. Pellow, J. (1982) The Home Office 1848 - 1914: From Clerks to Bureaucrats Heinemann, pp.132-3.
122. Priestley, P. op. cit. p.188.
123. Ibid, p.190.
124. P.R.O. P. Com. 2 165 (Kew Gardens).
125. Priestley, P. op. cit. p.188.
126. Ibid, p.190. (emphasis in the original).
127. Davis, J. (1980) "The London Garotting Panic of 1862: A Moral Panic and the Creation of a Criminal Class in mid-Victorian England" in Gatrell, V. et. al. op. cit. pp.190-213.
128. Tomlinson, M.H. (1981) "Penal Servitude 1846 - 1865: A System in Evolution" in Bailey, V. (ed) (1981) Policing and Punishment in Nineteenth Century Britain Croom-Helm p.141.
129. Observations in Parliamentary Debates 26 Vic 1863 Third Series Vol. 169 Cols. 475-493 (Home Office Library.)
130. Ibid, col. 478.
131. British Parliamentary Papers 1863 Vol. 6 Select Committee on Prison Discipline Irish University Press p.208.
132. McConville, S. op. cit. p.418.
133. Aberdeen M. - Cs Tracts 8TP 44 A 25 Wellcome Institute for the History of Medicine pp.62-3.
134. Ibid.
135. Guy, W. (1844) A Third Contribution to a Knowledge of the Influence of Employment Upon Health Wellcome Institute for the History of Medicine Pamphlet No. 1 p.10.
136. Guy, W. (1846-7) "On Medical Education: Being a Lecture Delivered at the Opening of the Medical Session 1846-7" in Aberdeen M - Cs Tracts 8 TP 44 A 25. Wellcome Institute for the History of Medicine p.21.
137. Guy, W. (1848) "The Case of the Journeymen Bakers: Being a Lecture on the Evils of the Night Work and Long Hours of Labour" in Wellcome Institute File T 508 p.14.
138. Ibid, pp.19-20.
139. McConville, S. op. cit. p.357.
140. Ibid, p.418.
141. Ibid.
142. Guy, W. (1863) "On Sufficient and Insufficient Dietaries with Especial Reference to the Dietaries of Prisoners" in Journal of the Statistical Society Vol. XXVI Part III p.280.
143. Cited in Priestley, P. op. cit. p.156.
144. Ibid.
145. P.R.O. H.O.45 9450/69228 1877-8 (Kew Gardens).
146. The Lancet 16th July 1864 p.77.
147. Ibid.
148. Ibid.
149. Ibid.
150. BMJ 5th September 1863 p.266.
151. BMJ 14th July 1866 p.45.
152. BMJ 7th March 1868 p.223.
153. Ibid.
154. The Lancet 4th April 1868 p.446.

155. Ibid.
156. Tomlinson, M.H. op. cit. p.143.
157. Ibid.
158. Priestley, P. op. cit. p.164.
159. Ibid, p.165.
160. BMJ 29th June 1878 p.936.
161. Association Medical Journal 16th February 1856 p.133.
162. Ibid.
163. Report of the Directors of Convict Prisons for the Year 1857  
Eyre and Spottiswoode Publishers (Home Office Library) pp.30-37.
164. Ibid.
165. Cited in Tomlinson, M.H. op. cit. p.133.
166. Cited in Priestley, P. op. cit. p.208. (emphasis in the original).
167. Ibid (emphasis in the original).
168. Ibid, p.210.
169. BMJ 6th October 1866 p.388.
170. BMJ 21st March 1868 p.292.
171. McConville, S. op. cit. p.440; Report of the Directors of Convict Prisons 1863-66 Return of Prisoners who have Received Punishment in Millbank Prison in the year 1863. Eyre and Spottiswoode Publishers (Home Office Library).
172. Ibid, Governors Report for Dartmoor pp.155-61.
173. Ibid, Chaplains Report for Millbank pp.70-1.
174. Smith, R. (1981) Trial by Medicine Edinburgh University Press p.32.
175. Cooter, R. (1979) "The Power of the Body: The Early Nineteenth Century" in Barnes, B., and Shapin, S. (eds) (1979) Natural Order: Historical Studies in Scientific Culture Sage p.85.
176. Doyal, L., and Pennell, I. (1979) The Political Economy of Health Pluto p.148.
177. R.M. Young cited in Ibid.
178. Rose, S., Kamin, L., and Lewontin, R. (1984) Not in our Genes Penguin p.55.
179. Ibid, pp.50-1.
180. McGrath, R. (1984) "Medical Police" in Ten 8: Quarterly Photographic Journal No. 14 pp.14-15.
181. Garland, D. (1985) Punishment and Welfare Gower pp.25-6.
182. Currie, E.P. (No Date) Managing the Minds of Men: The Reformatory Movement 1865-1920 unpublished Ph.D. Dissertation Department of Sociology University of California, Berkeley p.263.
183. Smith, R. op. cit. p.21.
184. Walker, N. (1968) Crime and Insanity in England Vol. 1 Edinburgh University Press.
185. Saunders, J. (1981) "Magistrates and Madmen: Segregating the Criminally Insane in Late - Nineteenth Century Warwickshire" in Bailey, V. op. cit. p.223.
186. Ibid, pp.223-4. These views were also extended to the question of race and the constitutional inferiority of the people of other lands. As D.A. Lorimar (1975) points out "by the 1860s many educated mid-Victorians had rejected all hope of alien peoples assimilating English ways, and even doubted if savages, including Africans, could survive the advances of white civilisation" Lorimar, D.A. (1975) Colour, Class and the Victorians Leicester University Press p.147.
187. Cited in McConville, S. op. cit. p.328.
188. Ibid, pp.328-9 (emphasis in the original).
189. BMJ 2nd December 1871 p.645.

190. P.R.O. H.O. 45/9371 382 63 (Kew Gardens).
191. Quinton, Dr. R.F. (1910) Crime and Criminals Longmans Green p.56.
192. Ibid, p.27.
193. The Lancet 8th February 1873 p.221.
194. Priestley, P. op. cit. p.129.
195. Cited in Griffiths, A. op. cit. p.196.
196. P.R.O. P. Com. 7331 (Kew Gardens).
197. The Lancet 14th December 1878 p.859.
198. Ibid. The Justices at Dorchester Prison made a similar complaint in January 1880 about the lack of consultation by the Home Office concerning events in the prison see P.R.O. H.O. 144 53 8990 (1879-80) (Kew Gardens).
199. The Lancet 9th August 1879 pp.209-210.
200. The Lancet 17th January 1880 p.104.
201. Ibid, p.105.
202. The Lancet 1888 Vol. 2 p.740.
203. The Lancet 1889 Vol. 2 p.1320.
204. Quinton, R. op. cit, p.62.
205. Ibid, p.256.
206. Merchant, A. (1869) Six Years in the Convict Prisons of England Richard Bentley, p.46.
207. Ibid, p.50.
208. Ibid, p.52.
209. One Who Has Endured it, (1877) Five Years' Penal Servitude Richard Bentley.
210. One Who Has Tried Them, (1881) Her Majesty's Prisons, Their Effects and Defects Vol. 2, Sampson Low, Marston, Searle and Rivington.
211. Ibid, pp.104-5.
212. Ibid, pp.117-18.
213. Cited in Priestley, P. op. cit. p.205.
214. The Lancet 10th February 1866 p.152.
215. BMJ 2nd February 1878 pp.163-4; 6th April 1878 pp.494-5.
216. Quinton, R.F. op. cit. pp.188-89.
217. BMJ 8th April, 22nd April, 27th May, 17th June 1871.
218. The Lancet 6th September 1879 p.373.
219. Copy of the Report Made and Evidence Taken by the Commissioner Appointed to Inquire into the Circumstances of the Death of John Nolan in Clerkenwell Prison Home Office 25th February 1879. Matthew White Ridley p.3.
220. Press report of the case in P.R.O. H.O. 45 9471 79161 (Kew Gardens).
221. "Copy of the Depositions taken before the Coroner at the Inquest on the body of John Nolan" in Copy of the Report Made. op. cit. pp.3-4.
222. Copy of the Report Made ..... op. cit. p.12.
223. Ibid, p.36.
224. The Lancet 1879 Vol. 2 p.823.
225. The Lancet 7th February 1880 p.222.
226. Ibid, p.223.
227. The Lancet 10th July 1880 p.62.
228. The Lancet 31st July 1880 p.182.
229. Ibid.
230. The Lancet 18th June 1881 p.1003.
231. The Lancet 17th December 1881 p.1058.
232. The Lancet 21st January 1882 p.120.

233. The Lancet 15th April 1882 p.616.
234. The Lancet 29th April 1882 pp.698-99.
235. BMJ 29th April 1882 p.587.
236. BMJ 6th May 1882 p.680.
237. Ibid.
238. The Lancet 20th May 1882 p.834.
239. The Lancet 10th June 1882 p.968.
240. The Lancet 17th June 1882 p.996.
241. The Lancet 24th June 1882 p.1047.
242. The Lancet 2nd December 1882 p.952.
243. The Lancet 12th March 1887 p.530.
244. BMJ 7th march 1885.
245. The Lancet 9th March 1895 p.626.
246. Ibid., p.634.
247. The Lancet 16th March 1895 p.708.
248. The Lancet 30th March 1895 p.839. Serious questions were also being raised about the state of medical care in Duke Street prison, Glasgow. See The Lancet 1st July 1899 p.64.
249. BMJ 23rd December 1893 p.1398.
250. Garland, D. op. cit. p.236.
251. BMJ 31st March 1888 p.707.
252. Garland, D. (1981) "The Birth of the Welfare Sanction" in British Journal of Law and Society Vol. 8 No. 1 p.38.
253. Medical Times and Gazette 17th October 1885 pp.550-1.
254. The Lancet 8th May 1886 p.891.
255. The Lancet 9th February 1889 pp.281-2.
256. Ibid.
257. Garland, D. (1985) op. cit. p.148.
258. The Lancet 25th January 1890 p.189.
259. The Lancet 8th February 1890 p.305.
260. The Lancet 31st May, 1890 p.1173.
261. The Lancet 4th October 1890 p.737.
262. The Lancet Vol. 2 1892 pp.370-1.
263. Morel, J. (1892) "The Psychological Examination of Prisoners" in Journal of Mental Science Vol. 39 1892 pp.13-14.
264. Ibid., p.15.
265. The Lancet 14th October 1893 p.940.
266. The Lancet 24th February 1894 p.487.
267. The Lancet 15th July 1893 p.146.
268. Ibid., p.147.
269. The Lancet 19th November 1898 p.1343.
270. The Lancet 13th March 1897 p.751.
271. The Lancet 11th August 1890 p.412.
272. Ibid., p.446.
273. Ibid.
274. The Lancet 20th January 1890 p.169.
275. The Lancet 18th January 1873 p.102.
276. Ibid.
277. Ibid.
278. The Lancet 15th February 1879 p.240.
279. The Lancet 16th August 1879 p.248.
280. Griffiths, A. (1905) op. cit. p.145.
281. Ibid.
282. The Lancet 9th January 1875 p.71.
283. The Lancet 5th June 1875 p.298.
284. The Lancet 11th March 1876 p.400.
285. Ibid.

286. The Lancet 7th July 1877 p.18.
287. The Lancet 21st April 1877 p.579.
288. The Lancet 8th December 1888 p.1142.
289. The Lancet 17th August 1889 p.321.
290. Quinton, R.F. op. cit. pxi.
291. Ibid, p.228.
292. Ibid, p.203.
293. Jones, G. Stedman (1971) Outcast London Clarendon Press.
294. Quinton, R.F. op. cit. pp.99-100.
295. Anderson, R.D. (1878) The Prison Acts 1877 and 1865 Sham and Sons pp.36-7.
296. Quinton, R.F. op. cit. p.18.
297. Ibid, p.19.
298. Ibid, p.15.
299. Ibid, pp.12-13.
300. Ibid, pp.21-27.
301. Ibid, pp.225-7.
302. Campbell, J. (1884) Thirty Years Experience of a Medical Officer in the English Convict Service Nelson and Sons pp.130-33.
303. Ibid, pp.73-4.
304. Ibid, pp.128-9.
305. The Lancet 12th October 1895 p.911.
306. The latest in this line is Stern, V. (1987) Bricks of Shame Penguin p.60.
307. Gatrell, V. (1980) "The Decline of Theft and Violence in Victorian and Edwardian England" in Gatrell, V. et. al. (eds) op. cit. p.83.
308. Ibid.
309. Young, P. (1983) "Sociology, the State and Penal Relations" in Garland, D., and Young, P. (eds) (1983) The Power to Punish Heinemann p.97.
310. The Lancet 11th September 1897 p.669.
311. Statement by the Prison Commissioners of the Action which has been taken up to January 1898 to carry out the Recommendations in the Report of the Departmental Committee on Prisons, 1895 HMSO Blue Book Institute of Criminology, Cambridge p.29.
312. The Lancet 19th March 1898 p.799.
313. Ibid.
314. Ibid.
315. Cited in Turner, E.S. (1958) Call the Doctor: A Social History of Medical Men Michael Joseph p.214.

CHAPTER 5

1. Ignatieff, M. (1978) A Just Measure of Pain MacMillan p.219.
2. Garland, D. (1988) "British Criminology Before 1935" in Rock, P. (ed) (1988) A History of British Criminology: British Journal of Criminology, Vol. 28, No. 2, Spring 1988, pp.4-5.
3. Ibid.
4. Ibid, p.5.
5. Watson, S. (1988) The Moral Imbecile: A Study of the Relations Between Penal Practice and Psychiatric Knowledge of the Habitual Offender, A Dissertation submitted to University of Lancaster, January 1988, p.132.
6. Ibid.
7. The Lancet Vol. 2 1907 p.268.
8. Ibid.
9. Watson, S. op. cit. pp.258-9.
10. Ibid, pp.140-1.
11. Ibid, pp.95-6.
12. Ibid, p.132.
13. Ibid, p.133.
14. Ibid, p.157.
15. Ibid.
16. P.R.O. Prison Com. 7 326 1922 (Kew Gardens).
17. Watson, S. op. cit. pp.133-4.
18. Ibid, p.145.
19. Ibid.
20. Smith, M. Hamblin (1934) Prisons John Lane, The Bodley Head Ltd. p.130.
21. Ibid, p.139.
22. Ibid, p.143.
23. Ibid, p.146.
24. See recommendations 46 and 47 of the House of Commons Third Report from the Social Services Committee Session 1985-86, Prison Medical Service, Vol. 1, 25th June 1986, p.1X111.
25. P.R.O. H.O. 45 1110 34 A53933 Document 10, (Kew Gardens).
26. Ibid.
27. Ibid.
28. Ibid.
29. Ibid, File 26.
30. Ibid.
31. Ibid, File 29.
32. Watson, S. op. cit. p.135.
33. P.R.O. H.O.45 18366 122929/7, Letter 10th December 1904 (Kew Gardens).
34. Ibid.
35. Ibid.
36. The Lancet 25th November 1905 p.1556.
37. Simmons, H. (1978) "Explaining Social Policy: The English Mental Deficiency Act of 1913" in Journal of Social History Vol. 11 1978 p.391.
38. Garland, D. (1985) Punishment and Welfare, Gower p.223.
39. Ibid, p.224.
40. Ibid, p.225.
41. The Lancet 25th November 1925 p.1557.
42. The Lancet 17th October 1908 p.1156.
43. Mort, F. (1987) Dangerous Sexualities RKP pp.171-2.
44. Garland, D. op. cit. pp.153-4 (emphasis in the original).

45. Hobhouse, S., and Brockway, F. (1922) English Prisons Today, Longmans p.261.
46. Ibid, p.290.
47. Ibid.
48. Ibid, pp.288-9.
49. Ibid, p.291. The state, however, still made distinctions in the punishment for British and foreign prisoners. In August 1917, it was recommended that figure of 8 handcuffs should be discontinued in British prisons but that colonial governments should retain them as "negroes, in particular, are apt to be of great muscular power and a very passionate temperament" P.R.O. H.O. 45 18366 122929/14 13th August 1917 (Kew Gardens).
50. MacCartney, W.C. (1936) Walls Have Mouths, Victor Gollancz, p.292.
51. Ibid, p.165.
52. Ibid, pp.165-6.
53. Ibid, p.103.
54. Ibid, pp.123-4.
55. Ibid, pp.312-13.
56. Red Collar Man (1937) Chokey Victor Gollancz p.122.
57. Ibid, p.155.
58. Ibid, pp.116-17.
59. Ibid, p.69.
60. Ibid, pp.69-70.
61. Clayton, G.F. (1958) The Wall is Strong John Long p.164.
62. Ibid, pp.164-5.
63. Richmond, G. (1975) Prison Doctor, Nunaga Publishing, p.11.
64. Ibid, p.13.
65. Ibid, p.16.
66. Ibid, pp.17-18.
67. Garland, D. op. cit. p.254.
68. Jones, H. (1965) Crime in a Changing Society Penguin pp.116-117.
69. Fitzgerald, M., and Sim, J. (1982) British Prisons Blackwell 2nd Edition, Chapter 4.
70. Cohen, S. (1985) Visions of Social Control Polity pp.194-5.
71. Ryan, M. (1983) The Politics of Penal Reform Longman p.35.
72. Fitzgerald, M. and Sim, J. op. cit. Ryan, M. op. cit; Wright, M. (1982) Making Good Burnett Books.
73. Cohen, S., and Taylor, L. (1981) Psychological Survival 2nd Edition Penguin p.10.
74. King, R. (1985) "Control in Prisons" in Maguire, M. et. al. (eds) (1985) Accountability and Prisons Tavistock p.191.
75. Sinn Fein (1980) Irish Political Prisoners in England Sinn Fein p.11.
76. The Guardian 17th November 1986.
77. Greater London Council Women's Committee (1986) Breaking the Silence London Strategic Policy Unit p.165.
78. Hansard 1st February 1980 cols. 821-2.
79. Prison Reform Trust (1984) Parliamentary All-Party Penal Affairs Group: Working Party on Life Sentence Prisoners. Submission by the Prison Reform Trust p.3.
80. The Independent 24th February 1988.
81. BBC Radio 4 News 19th November 1987.
82. Samuel, R. (1981) East End Underworld RKP p.161.
83. Abse, L. (1973) Private Member MacDonald pp.121-2.
84. Miller, A. (1976) Inside Outside Queensgate p.116.

85. The Guardian 16th December 1982.
86. Wakefield, D. (1980) A Thousand Days in Solitary P.R.O.P. p.26.
87. Ibid.
88. Sinn Fein op. cit. p.42.
89. Laycock, G. (1983) "Highly Dangerous Prisoners" in Home Office Research and Planning Unit Research Bulletin No. 15.
90. Hansard 19th January 1984 cols. 281-2.
91. King, R., and Morgan, R. (1980) The Future of the Prison System Gower p.79.
92. Home Office (1984) Managing the Long-Term Prison System HMSO Annex D.
93. Fitzgerald, M., and Sim J. op. cit.
94. King, R. op. cit. p.191.
95. Ibid, p.189.
96. Draft Memorandum Submitted by Prison Medical Officers to the Royal Commission on the Prison System. H.M. Prison Service Staff College Library Wakefield p.4.
97. The Times 20th May 1970.
98. Home Office (1969) People in Prison: England and Wales HMSO p.22.
99. Miller, A. op. cit. p.103.
100. Fitzgerald, M. (1977) Prisoners in Revolt Penguin.
101. Williams, J.E. Hall (1975) Changing Prisons Peter Owen pp.119-120.
102. Ibid.
103. Leigh, D. (1980) The Frontiers of Secrecy Junction p.121.
104. Ibid.
105. Birkinshaw, P. (1981) "The Control Unit Regime: Law and Order in Prisons" in Howard Journal Vol. XX 1981 p.70.
106. Notes from Documents in H.M. Prison Service College Library Wakefield.
107. Coggan, G., and Walker, M. (1982) Frightened for my Life Fontana pp.137-40.
108. Newsline (No Date) Britain's State within the State New Park Publications p.110.
109. Leigh, D. op. cit. p.125.
110. Ibid, p.126.
111. Wright, M. op. cit. p.53.
112. Cooper, D. (1973) "Straw in the Wind" in Prison Medical Journal Summer 1973 pp.19-27.
113. Ibid.
114. Ibid.
115. Ryan, M. op. cit. p.49.
116. Sinn Fein op. cit. p.73.
117. MacLaughlin, R. (1987) Inside an English Jail Borderline p.87.
118. Cited in Ryan, M. op. cit. p.58.
119. Thomas, J.E. and Pooley, R. (1980) The Exploding Prison Junction pp.104-5.
120. See Ibid, pp.98-118.
121. See P.R.O.P. (No Date) Don't Mark His Face P.R.O.P.
122. Thomas, J.E., and Pooley, R. op. cit. p.107.
123. Alexander, J. (1984) A Review of Protective Equipment for the Prison Service H.M. Prison Library Wakefield, p.1.
124. The Abolitionist No. 11, 1982, p.5.
125. Ibid.
126. Ibid, p.6. (emphasis in the original).



127. World in Action, (1982) Prisoners' Medicine 19th July 1982, 568/603 p.4.
128. Ibid, p.5.
129. Ibid.
130. Ibid, p.11.
131. H.M. Prison Birmingham Chief Inspectors Report, November 1981, Appendix 2, pp.35-6.
132. Ibid.
133. H.M. Prison Featherstone Chief Inspectors Report, January 1981, pp.29-30.
134. Alexander, J. op. cit. p.25.
135. Higman, D.W. (1984) North Region Training Programme 1984-5. H.M. Prison Service Staff College Library Wakefield, p.10.
136. Campbell, J. (1986) Gate Fever Weidenfeld and Nicolson, pp.86-7.
137. Owen, T. and Sim, J. (1984) "Drugs, Discipline and Prison Medicine: The Case of George Wilkinson" in Scraton, P. and Gordon, P. (eds) (1984) Causes for Concern Penguin p.243.
138. Read, P.P. (1978) The Train Robbers W.H. Allen, p.214.
139. Probyn, W. (1977) Angel Face Allen and Unwin, pp.108-9.
140. Miller, A. op. cit. pp.132-3.
141. Keeley, F. (1979) "The Home Office and the Liquid Cosh" in The Abolitionist January 1979 p.5.
142. Fitzgerald, M. and Sim, J. op. cit. pp.118-19.
143. Ibid.
144. Weekly Hansard Issue No. 1156 14-17th January, 1980 col 559.
145. Hansard 21st January 1980 cols. 15-16.
146. Hansard No. 1181 18-24th July 1980 col. 131.
147. Probe May 1979 p.8.
148. "Unpleasant but not painful: Medical Treatment of Sex Offenders" in The Abolitionist No.9, Autumn 1981, p.20.
149. Ibid.
150. Owen, T. (1980) The Use of Behaviour Modifying Drugs in British Prisons: An Analysis of the Medical Statistics Published in the 1979 Report on the Work of the Prison Department R.A.P. Briefing p.4.
151. Ibid, p.5.
152. Ibid.
153. Ibid, p.6.
154. Ibid, p.8.
155. Leigh, D. op. cit. p.112.
156. Leggett, B. (1980) "Drugs in Prison" in Probe Autumn 1980, pp.8-9.
157. Ibid.
158. The Daily Mirror, 8th December 1982.
159. The Guardian, 1st August 1980.
160. The Guardian 28th February 1986.
161. The Guardian 10th October 1984.
162. Cited in Shaw, S. (1985) "Introduction: The Case for Change in the Prison Medical Service" in Prison Reform Trust (1985) Prison Medicine: Ideas on Health Care in Penal Establishments, Prison Reform Trust, p.5.
163. Hansard 5th July, 1984 col. 224.
164. Hansard 23rd July 1984 col. 402-3.
165. The Times 23rd March 1984.
166. Whithead, I. (1985) "The Use of Psychotropic Drugs in Prison" in Prison Reform Trust op. cit. p.81.

167. Insiders 28th January 1986.
168. Fitzgerald, M. and Sim, J. op. cit.
169. Royal College of Psychiatrists (1979) "The College's Evidence to the Prison Services Inquiry" in Bulletin of the Royal College of Psychiatrists May 1979 p.83.
170. Howard Journal Vol. XVIII No.3 1979 p.132.
171. The Guardian 31st March 1982.
172. The Observer 16th October 1983.
173. The Guardian 19th August 1985.
174. House of Commons Social Services Committee Vol. 1 op. cit. para. 2.
175. Ibid, para. 5.
176. Ibid, para. 8.
177. Ibid, para. 11.
178. Ibid, para. 12.
179. House of Commons Third Report from the Social Services Committee Session 1985-86, Prison Medical Service vol. 2, Minutes of Evidence and Appendices p.83.
180. Ibid, p.84.
181. Ibid, p.83.
182. House of Commons Social Services Committee Vol. 1 op. cit. para. 13.
183. Ibid, para. 16.
184. Ibid.
185. Prison Reform Trust (1985) House of Commons Social Services Committee: Inquiry into the Prison Medical Services, Submission by the Prison Reform Trust, July 1985, p.19.
186. House of Commons Social Services Committee Vol. 2 op. cit. pp.82-3.
187. Ibid, p.62.
188. House of Commons Social Services Committee Vol. 1 op. cit. para.129.
189. The Government's Reply to the Third Report from the Social Services Committee Session 1985-86 Prison Medical Service HMSO.
190. Ibid, p.2-4.
191. Ibid, p.4.
192. Shaw, C. "Prison Medicine", in Open Mind, No. 26 April/May 1987, p.15.
193. The Guardian 27th February 1988.
194. The Guardian 6th May 1988.
195. The Guardian 3rd May 1988.
196. Ibid.
197. Ibid.
198. The Guardian 28th June 1988.
199. The Guardian 1st July 1988.
200. Liverpool Daily Post 1st July 1988.
201. The Independent 1st July 1988.
202. Liverpool Daily Post 1st July 1988.
203. The Independent 1st July 1988.
204. The Guardian 11th May 1988.
205. See the overviews by Gordon, P. (1983) Whitelaw Pluto; Scraton, P. (1985) The State of the Police Pluto; Sivanandan, A. (1982) A Different Hunger Pluto.
206. The Guardian 19th June 1986.
207. Greater London Council Ethnic Minorities Unit Policy Report (1985) Local Authorities and Penal Establishments: A Race Dimension, GLC, p.9.

- 208. Ibid, p.17.
- 209. The Guardian 13th June 1988.
- 210. Ibid.
- 211. Black Health Workers and Patients Group (1983) "Psychiatry and the Corporate State" in Race and Class Vol. XXV Autumn 1983, pp.60-1.
- 212. Ibid, p.60.
- 213. Black Health Workers and Patients Group op. cit. p.50.
- 214. The Observer 1st November 1987; The Independent 10th November 1987.
- 215. The Guardian 30th September 1987.
- 216. Ibid.
- 217. McGovern, D. and Cope, R. (1987) "The Compulsory Detention of Males of Different Ethnic Groups with Special Reference to Offender Patients" in British Journal of Psychiatry No. 150 1987 pp.505-12.
- 218. Cited in Benn, M. (1983) "Women in Prison: Breaking the Silence" in Spare Rib Issue 137, December 1983, pp.52-3.
- 219. The Guardian 30th March 1988.
- 220. Rutherford, A. (1983) Prisons and the Process of Justice Heinemann.
- 221. Box, S. and Hale, C. (1982) "Economic Crisis and the Rising Prisoner Population in England and Wales" in Crime and Social Justice No. 17. September 1982, pp.20-35.
- 222. Ibid, p.22.
- 223. Box, S. (1983) Power, Crime and Mystification Tavistock p.22.
- 224. Sim, J. (1987) "Working for the Clampdown: Prisons and Politics in England and Wales" in Scraton, P. (ed) (1987) Law, Order and the Authoritarian State, Open University Press, pp.190-211.
- 225. Poulantzas, N. (1978) State Power Socialism, New Left Books, Hall, S. (1985) "Authoritarian Populism: A Reply to Jessop et al" in New Left Review May/June 1985, pp.115-24; Hillyard, P. (1983) "Law and Order" in Darby, J. (ed) (1983) Northern Ireland: Background to Conflict Appletree Press, pp.32-60; Centre for Contemporary Cultural Studies (1982) The Empire Strikes Back Hutchinson.
- 226. Sim, J. op. cit.
- 227. Ignatieff, M. op. cit. p.220.

Chapter 6.

1. Elizabeth Gurley Flynn quoted in Partnow, E. (ed) (1978) The Quotable Woman Anchor Books p.200.
2. Allen, H. (1987) Justice Unbalanced Open University Press p.57.
3. Showalter, E. (1987) The Female Malady Virago p.6.
4. Spender, D. (1982) Women of Ideas (and What Men Have Done to Them) Ark.
5. Miller, P. and Rose, N. (1988) "The Tavistock Programme: The Government of Subjectivity and Social Life" in Sociology vol. 22 No. 2 May 1988 p.174.
6. Ibid, p.175.
7. For an excellent critique of conspiracy theory see Smart, C. (1984) The Ties That Bind R.K.P.; Brophy, J. and Smart, C. (eds) (1985) Women in Law R.K.P.
8. Allen, H. op. cit. p.12.
9. Ibid, p.13.
10. Ibid, p.14.
11. Ibid, pp.111-12 (emphasis in the original).
12. Smart, B. (1985) Michel Foucault Tavistock p.79.
13. Ibid.
14. Harrison, R. and Mort, F. (1980) "Patriarchal Aspects of Nineteenth Century State Formation" in Corrigan, P. (ed) (1980) Capitalism, State Formation and Marxist Theory Quartet p.107.
15. Carlen, P. and Worrall, A. (1987) "Introduction: Gender, Crime and Justice" in Carlen, P. and Worrall, A. (eds) (1987) Gender, Crime and Justice Open University Press p.2.
16. Ibid, pp.3-4.
17. Edwards, S. (1984) Women on Trial Manchester University Press p.82.
18. Cited in Whiting, J. (1975) Prison Reform in Gloucestershire 1776-1820 Phillimore and Co. p.44.
19. Ibid.
20. Showalter, E. op. cit. p.17.
21. Ignatieff, M. cited in Ibid p.50.
22. Ignatieff, M. (1978) A Just Measure of Pain MacMillan p.144.
23. Rose, J. (1980) Elizabeth Fry MacMillan p.84.
24. Ibid, pp.134-5.
25. Dobash, R. Dobash, R.E. and Gutteridge, S. (1986) The Imprisonment of Women Blackwell p.79.
26. Ibid.
27. Cited in Priestley, P. (1985) Victorian Prison Lives Methuen p.214.
28. Cited in Heidensohn, F. (1985) Women and Crime MacMillan p.66
29. Dobash, R. et. al. op. cit. p.80. When transportation was in use, women were violently repressed. They were in the words of Robert Hughes "the prisoners of prisoners" where degradation, violence and enforced slavery were part of their everyday lives. See Hughes, R. (1987) The Fatal Shore Guild pp.258-64.
30. Ibid, p.83.
31. Walkowitz, J. (1980) Prostitution and Victorian Society Cambridge University Press p.220.
32. Ibid, p.222.

33. Ibid, p.221.
34. Ibid, p.215.
35. Showalter, F. op. cit. p.81.
36. Ibid.
37. Griffiths, A. (1905) Fifty Years of Public Service Cassell p.205.
38. Ibid, pp.205-6.
39. Ibid, p.206.
40. Ibid. p.207.
41. Ibid, p.208.
42. Ibid, pp.208-9.
43. Ibid, p.209.
44. Ibid, p.205.
45. Ibid, pp.210-12.
46. Griffiths, A. (1884) Memorials of Millbank and Chapters in Prison History Chapman and Hall pp.117-18.
47. Ibid, p.198.
48. Prison Matron (1864) Female Life in Prison Sampson, Low & Son and Marston.
49. Ibid, p.26.
50. Ibid, p.102.
51. Ibid, p.48.
52. Ibid, p.26.
53. Ibid, p.79.
54. Ibid, p.81.
55. Ibid, p.29.
56. Ibid, p.72.
57. Cited in the Preface to the New Edition of Prison Matron op. cit.
58. Ibid, p.239.
59. Ibid, p.185.
60. Ibid, p.264.
61. Quinton, R.F. (1910) Crime and Criminals Longmans Green p.42.
62. Ibid, pp.138-40; p.239.
63. Ibid, pp.140-1.
64. Ibid, pp.141-2.
65. BMJ 7th March 1885.
66. Ibid.
67. Size, M. (1957) Prisons I Have Known Allen and Unwin pp.38; 44; 89; 112.
68. Ibid, pp.90-1.
69. Kelley, J. (1967) When the Gates Shut Longmans, Green and Co. p.166.
70. Fletcher, S.W. (1884) Twelve Months in an English Prison Lee and Shepard pp.322-3.
71. Ibid, p.388.
72. Maybrick, F.E. (1905) Mrs. Maybrick's Own Story: My Fifteen Lost Years Funk and Wagnalls Company p.121.
73. Ibid, pp.121-2.
74. Ibid, pp.116-7.
75. Ibid, pp.126.
76. Ibid, p.189.
77. Showalter, E. op. cit. p.75.
78. Ibid, p.76.
79. Ibid, p.107.
80. Ibid.
81. Ibid.

82. Dobash, R. et. al. op. cit. p.114.
83. Showalter, F. op. cit. pp.107-8.
84. The Lancet vol 2 1900 p.367.
85. Ibid.
86. The Lancet 24th May 1904 p.1477.
87. The Lancet 7th May 1904 p.1292.
88. The Lancet 18th August 1906 p.448.
89. The Lancet 15th July 1905 p.170.
90. "The Proposed Sterilization of Certain Degenerates" in Transactions of the Medico-Legal Society 1904/5 Vol. 2 p.24.
91. Ibid, pp.23-4.
92. Ibid, p.25.
93. Ibid, p.22 (emphasis in the original).
94. Eastlea, B. (1981) Science and Sexual Oppression Weidenfeld and Nicolson p.160.
95. Ibid, pp.160-1.
96. Ibid, p.163.
97. Cited in Garland, D. (1985) Punishment and Welfare Gower p.227.
98. Simmons, H. (1978) "Explaining Social Policy: The English Mental Defficiency Act of 1913" in Journal of Social History Vol. 11 1978 pp.292-4.
99. Ibid.
100. Ibid.
101. Ibid, p.397.
102. MacKenzie, D. (1976) "Eugenics in Britain" in Social Studies of Science 6 1976 pp.503-18.
103. Ibid, p.505.
104. Ibid, pp.516-17.
105. Ibid, p.522.
106. Dobash, R. et. al. op. cit. p.116.
107. Ibid, p.119.
108. Ibid.
109. Farral, L.A. (1979) "The History of Eugenics: A Bibliographical Review" in Annals of Science 36 1979 p.116.
110. Rose, N. (1985) The Psychological Complex R.K.P. p.52.
111. Ibid, p.83.
112. Ibid, pp.85-6.
113. The Lancet 15th April 1905 p.1010.
114. Ibid.
115. Rose, N. op. cit. p.103.
116. Ibid, p.128.
117. Sullivan, W.C. (1912) "Feeble-Mindedness and the Measurement of Intelligence by the Method of Binet and Simon" in The Lancet 23rd March 1912 pp.777-80.
118. Ibid, p.778.
119. Sullivan, W.C. (1921) "Crime and Mental Defficiency" in The Lancet 15th October 1921 p.789.
120. East, W.N. (1921) "A Case of Moral Imbecility" in The Lancet 19th November 1921 p.1051.
121. Ibid, p.1056.
122. See Watson, S. (1988) The Moral Imbecile: A Study of the Relations Between Penal Practice and Psychiatric Knowledge of the Habitual Offender. A Dissertation submitted to the University of Lancaster January 1988 p.198; 297.
123. Prison Matron, op. cit. p.252.
124. Size, M. op. cit. p.110.

125. Cited in Camp, J. (1974) Holloway Prison: The Place and the People David and Charles p.62.
126. Size, M. op. cit. p.110.
127. The Lancet 20th August 1904 p.554.
128. Ibid.
129. Ibid, pp.553-4.
130. Size, M. op. cit. pp.110-11.
131. Ibid, p.64.
132. Ibid.
133. Camp, J. op. cit. p.97; Size, M. op. cit. p.115.
134. Size, M. op. cit. p.120.
135. See The Liverpool South West Lancashire and Wirral Discharged Prisoners' Aid Society in connection with H. M. Prison Liverpool Annual Reports 1913-1923, The Gainsboro Press 1924.
136. Ibid, 1913 Report p.3.
137. Ibid, 1916 Report pp.18-19.
138. Ibid, 1913 Report p.10.
139. Size, M. op. cit. p.55.
140. The Lancet Vol. 1 1908 pp.42-3.
141. Public Record. Office P Com 7 318 (Kew Gardens.)
142. Ibid.
143. Size, M. op. cit. pp.76-7.
144. Public Record. Office P Com 7 326 (Kew Gardens).
145. Ibid.
146. Radzinowicz L. and Hood, R. (1979) "The Status of Political Prisoners in England: The Struggle for Recognition" in Virginia Law Review Vol. 65 No. 8 p.1466.
147. Lytton, C. (1976) Prisons and Prisoners: Experiences of a Suffragette E.P. Publishing pp.268-70.
148. Rich, C.E.F. (1932) Recollections of a Prison Governor Hurst and Blackett pp.178-9 (emphasis in the original).
149. P.R.O. P Com 7 40 9670 (Kew Gardens).
150. Ibid.
151. Ibid.
152. Hobhouse, S. and Brockway, A.F. (1922) English Prisons Today Longmans p.340.
153. P.R.O. P Com 7 40 9670 op. cit.
154. Ibid.
155. Cited in Heidensohn, F. op. cit. p.66.
156. P.R.O. HO 45 11135 (Kew Gardens).
157. Hobhouse, S. and Brockway, F. op. cit. p.336.
158. Ibid, p.339.
159. Ibid, pp.351-2.
160. Ibid, p.345.
161. Ibid, p.337.
162. Ibid, pp.345-6.
163. Cited in Camp, J. op. cit. pp.75-6.
164. Gordon, M. (1922) Penal Discipline R.K.P. pp.234-5.
165. Kennedy, L. (1988) Review of "Criminal Justice: The True Story of Edith Thompson" by Rene Weis in The Observer 17th July 1988.
166. Weis, R. (1988) Criminal Justice: The True Story of Edith Thompson Hamish Hamilton p.301.
167. Gordon, M. op. cit. p.46.
168. Ibid, p.29.
169. Ibid, p.236 (emphasis in the original).
170. The Lancet 23rd September 1922 p.664.

171. Cited in Calvert, F.R. and Calvert, T. (1933) The Lawbreaker George Routledge and Sons p.233.
172. Ibid, p.231.
173. P.R.O. Prison Commissioners 9 192 (Kew Gardens).
174. Ibid.
175. P.R.O. Prison Commissioners 9 31 (Kew Gardens).
176. Ibid.
177. Dobash, R. et. al. op. cit. p.120.
178. Ibid, p.121.
179. Ibid.
180. Calvert, F.R. and Calvert, T. op. cit. p.228.
181. Blacker, C.P. (ed) (1937) A Social Problem Group? Oxford University Press p.4.
182. Cited in Ibid, pp.128-50 (emphasis in the original).
183. The Times 15th February 1947; The Times 9th August 1949; The Times 5th August 1949.
184. Elkin, W. (1957) The English Penal System Pelican p.145.
185. Henry, J. (1952) Women in Prison Doubleday p.86.
186. Report of the Commissioners of Prisons and Directors of Convict Prisons (hereafter RCPDCP) 1945 p.73.
187. Ibid.
188. RCPDCP 1946 p.59.
189. RCPDCP 1948 p.57.
190. RCPDCP 1949 p.125.
191. Ibid, p.28.
192. Ibid, p.129 (emphasis in the original).
193. The Times 8th March 1952.
194. Report of the Commissioners of Prisons (hereafter RCP) 1952 p.40.
195. RCP 1954 p.144.
196. RCP 1953 p.58.
197. Ibid.
198. Ibid, p.59.
199. RCP 1954 p.137.
200. RCP 1953 p.56.
201. Ibid.
202. Fox, L. (1952) The English Prison and Borstal Systems R.K.P. pp.154-5 (emphasis in the original).
203. Ibid.
204. RCP 1961 p.52.
205. Ibid, p.51.
206. Ibid, p.52.
207. Size, M. op. cit. pp.188-9.
208. RCP 1960 p.58.
209. Benney, M. (1948) Gaol Delivery Longmans Green and Co. p.120.
210. Size, M. op. cit. p.139.
211. Ibid, p.152.
212. Ibid.
213. Kelley, J. (1957) "Some Aspects of the Work at Askham Grange Open Prison for Women" in Journal of the Medical Women's Federation July 1957 p.195.
214. Ibid.
215. Prison Medical Reform Council (1943c) Prison for Women: Some Accounts of Life in Holloway Prison for Women Prison Medical Reform Council pp.18-19.
216. Ibid.
217. Ibid.



218. Ibid.
219. Henry, J. *op. cit.* pp.84-5.
220. Ibid, pp.54-5.
221. RCP 1952 p.142.
222. Cited in Showalter, F. *op. cit.* pp.209-10.
223. Hudson, D. (1987) "You Can't Commit Violence Against an Object: Women, Psychiatry and Psychosurgery" in Hanmer, J. and Maynard, M. (eds) (1987) Women, Violence and Social Control MacMillan p.113.
224. Cited in Cohen, D. (no date) Broadmoor Psychology Press News p.67.
225. Epps, P. (1951) "A Preliminary Survey of 300 Female Delinquents in Borstal Institutions" in British Journal of Delinquency Vol. 1 January 1951 p.187.
226. Ibid, pp.187-92.
227. Ibid, pp.194-7.
228. Epps, P. and Parnell, R.W. (1952) "Physique and Temperament of Women Delinquents Compared with Women Undergraduates" in British Journal of Medical Psychology Vol. XXV Part 4 p.254.
229. Epps, P.C. (1954) "A Further Survey of Female Delinquents Undergoing Borstal Training" in British Journal of Delinquency Vol. 4 Part 4 pp.270-1.
230. BMJ 30th December 1961 p.1752-3. Dalton's argument was supported by a letter in the BMJ in March 1962. It was from Nairobi. The writer pointed out that he had performed a number of necropsies on Hindu women who had committed suicide by pouring kerosene over their bodies and setting it alight. Out of 22 cases, 19 had been menstruating at the time. Additionally the writer also found the same thing in women of different races four of whom had committed suicide by other means. All had been menstruating (BMJ 3rd March 1962 p.640).
231. Woodside, M. (1962) "Instability of Women Prisoners" in The Lancet 3rd November 1962 p.928-9.
232. Ibid, p.930.
233. RCP 1961 p.51.
234. Carlen, P. and Worrall, A. *op. cit.* p.4.
235. RCP 1963 p.44.
236. Kelley, J. *op. cit.* p.53.
237. Ibid, p.54.
238. Ibid, p.125.
239. Ibid, pp.102-3.
240. Ibid, p.125.
241. Ibid, p.135.
242. Ibid, p.63.
243. Ibid, p.75.
244. Ibid, p.79.
245. Ibid, p.66.
246. Ibid. p.178.
247. Ibid, p.60.
248. Morgan, A.M. (1964) "Women in Preventive Detention" in Prison Service Journal Vol. 4 Part 13 October 1964 p.21.
249. RCP 1961 p.97.
250. Henry, J. *op. cit.* pp.65-6.
251. Buxton, J. and Turner, M. (1962) Gate Fever The Cresset Press p.58.
252. Field, Xenia (1963) Under Lock and Key Mave, Pamish and Co. Ltd p.157.

- 253. Ibid, p.162
- 254. Kelley, J. op. cit. p.104.
- 255. Ibid, p.106.
- 256. Field, X. op. cit. p.164.
- 257. Ibid, p.163.
- 258. Report of the Work of the Prison Department (hereafter RWPD) 1964 p.39.
- 259. Ibid.
- 260. Ibid.
- 261. Prison Medical Journal No. 2 July 1965 p.23.
- 262. The Times 11th July 1966.
- 263. Memorandum submitted by Prison Medical Officers to the Royal Commission on the Penal System H. M. Prison Service College Library Wakefield p.1.
- 264. RWPD 1967 p.19.
- 265. Smith, A. (1965) "Penal Policy and the Female Offender" in Halmos, P. (ed) (1965) Sociological Review Monograph No. 9 University of Keele p.114.
- 266. Ibid, p.130.
- 267. Minutes of the Regional Conference of Governors held at Haverigg Prison 10th June 1969 H. M. Prison Service College Library Wakefield p.3.
- 268. Ibid, p.4.
- 269. Dobash, R. et. al. p.127.
- 270. Ibid, pp.127-9.
- 271. Cited in Morris, A. (1987) Women, Crime and Criminal Justice Basil Blackwell p.109.
- 272. Ibid, p.110.
- 273. Home Office (1969) People in Prison England and Wales HMSO pp.61-2.
- 274. Camp, J. op. cit. pp.149-51.
- 275. Ibid.
- 276. Ibid, p.153.
- 277. Ibid, p.154.
- 278. Smart, C. (1976) Women Crime and Criminology R.K.P. pp.144-5.
- 279. BMJ 7th October 1972 p.58.
- 280. Cited in Heidensohn, F. (1980) Women and the Penal System Paper presented at the Cropwood Round-table Conference on Women and Crime 1980 pp.6-7.
- 281. Ibid, p.7.
- 282. Matthews, J. (1980) Women in the Penal System NACRO.
- 283. Ibid, p.4.
- 284. H. M. Prison Holloway: Purpose and Regime PDG/77 184/177/3 H. M. Prison Service Staff Library Wakefield p.2.
- 285. Ibid.
- 286. Ibid.
- 287. Ibid, pp.2-3.
- 288. Ibid p.3.
- 289. Ibid, p.4.
- 290. Cited in Padel, U. and Stevenson, P. (1988) Insiders Virago pp.170-1.
- 291. Hansard 6th March 1984 col. 542.
- 292. The Abolitionist No. 17 1984 p.18.
- 293. The Abolitionist No. 16 1984 p.16.
- 294. The Abolitionist No. 19 1985 p.19.
- 295. Ibid.
- 296. The Abolitionist No. 22 1986 p.21.

297. The Abolitionist No. 20 1985 p.20.
298. Open Space, (1984) "The Women of Durham Jail" Transcript February 1984 p.10.
299. The Abolitionist No. 17 1984 p.19.
300. Padel, U. and Stevenson, P. op. cit. p.10.
301. Ibid, p.38.
302. Carlen, P. (1982) "Papa's Discipline: An Analysis of Disciplinary Modes in the Scottish Women's Prison" in Sociological Review Vol. 30 No. 1 pp.119-20.
303. The Guardian 14th March 1983.
304. Allen, H. op. cit. p.59 (emphasis in the original).
305. Carlen, P. (1983) Women's Imprisonment R.K.P. p.210.  
See also Rowelt, C. and Vaughan, P. (1981) "Women and Broadmoor: Treatment and Control in a Special Hospital" in Hutter, B. and Williams, G. (eds) (1981) Controlling Women Croom Helm pp.131-53.
306. For an analysis of the figures for the early 1980s see Owen, T. and Sim, J. (1984) "Drugs, Discipline and Prison Medicine: The Case of George Wilkinson" in Scraton, P. and Gordon, P. (eds) (1984) Causes for Concern Penguin pp.228-55.
307. Carlen, P. op. cit. pp.200-1.
308. Mandaraka-Sheppard, A. (1986) The Dynamics of Aggression in Women's Prisons in England Gower p.208.
309. Genders, E. and Player, E. (1987) "Women in Prison: The Treatment, the Control and the Experience" in Carlen, P. and Worrall, A. op. cit. p.165.
310. See Padel, U. and Stevenson, P. op. cit. p.58; House of Commons Third Report from the Social Services Committee Session 1985-6 Prison Medical Service Vol. 2 Minutes of Evidence and Appendices p.93.
311. Benn, M. and Tchaikovsky, C. (1983) "Women Behind Bars" in New Statesman 9th December 1983 p.8.
312. Greater London Council Women's Committee (1986) Breaking the Silence London Strategic Policy Unit p.154.
313. Ibid, p.155.
314. The Guardian 12th October 1984.
315. Ibid.
316. The Guardian 11th November 1985.
317. The Guardian 22nd May 1985.
318. The Observer 23rd March 1986.
319. Ibid.
320. Carlen, P., Hicks, J., O'Dwyer, J., Christina, D. and Tchaikovsky, C. (1985) Criminal Women Polity Press p.188.
321. Ibid.
322. Greater London Council Women's Committee op. cit. pp.179-80.
323. See The Abolitionist Nos. 17, 18, 19, 21.
324. The Abolitionist No. 22 1986 p.23.
325. Ibid.
326. Carlen, P. (1985) "Law, Psychiatry and Women's Imprisonment: A Sociological View" in British Journal of Psychiatry 146 (1985) p.620.

Chapter 7.

1. Donnelly, M. (1986) "Foucault's Genealogy of the Human Sciences" in Gane, M. (ed) (1986) Towards A Critique of Foucault R.K.P. p.19.
2. Taussing, M. (1987) Shamanism, Colonialism and the Wild Man: A Study in Terror and Healing University of Chicago Press.
3. Mullin, C. (1986) Error of Judgement Chatto and Windus; Kee, R. (1986) Trial and Error Hamish Hamilton; Foot, P. (1986) Murder at the Farm Sidgwick and Jackson.
4. Report of the Independent Committee of Inquiry, (1987) The Roof Comes Off The Gateway Exchange.
5. Beresford, D. (1987) Ten Men Dead Grafton; Sands, B. (1983) One Day In My Life Pluto.
6. Soyinka, W. (1985) The Man Died. Arrow.
7. Steinert, H. (1980) "The Development of 'Discipline' According to Michel Foucault: Discourse Analysis vs. Social History" in Crime and Social Justice No. 20 p.96.
8. Ibid.
9. De Sousa Santos, B. (1985) "On Modes of Production of Law and Social Power" in International Journal of the Sociology of Law Vol. 13 1985 p.325.
10. Ibid.
11. Ibid, p.327.
12. Poulantzas, N. (1978) State Power Socialism New Left Books p.146.
13. Ibid, p.148 (emphasis in the original).
14. Ibid, p.149.
15. Ibid, p.151.
16. Ibid, p.81 (emphasis in the original).
17. Ingleby, D. (1983) "Mental Health and Social Order" in Cohen, S. and Scull, A. (eds) (1983) Social Control and the State Martin Robertson pp.141-88.
18. Sedgwick, P. (1982) Psycho Politics Pluto.
19. Miller, P. and Rose, N. (1988) "The Tavistock Programme: The Government of Subjectivity and Social Life" in Sociology Vol. 22 No. 2 May 1988 p.174.
20. Hall, S. and Schwarz B. (1985) "State and Society 1880-1930" in Langan, M. and Schwarz, B. (eds) (1985) Crises in the British State 1880-1930 Hutchinson pp.19-20.
21. Clarke, J. (1985) "Managing the Delinquent: the Children's Branch of the Home Office 1913-30" in Ibid, p.252 (emphasis in the original).
22. MacKinnon, C. (1987) "Feminism, Marxism, Method and the State: Towards Feminist Jurisprudence" in Harding, S. (ed) (1987) Feminism and Methodology Open University Press p.136; Connell, R.W. (1987) Gender and Power Polity pp.125-32.
23. Oakley, A. (1982) Subject Women Fontana; Stacey, M. and Price, M. (1981) Women, Power and Politics Tavistock; Spencer, A. and Podmore, D. (eds) (1987) In A Man's World: Essays on Women in Male-Dominated Professions Tavistock; Sassoon, A. S.(ed) (1987) Women and the State Hutchinson
24. Connell, R.W. op. cit. p.130.

25. Hansard 12th May 1982 col. 230.
26. Rose, S., Kamin, L. and Lewontin, R. (1984) Not In Our Genes Penguin; Milton Keynes Citizen 4th November 1982.
27. The Sun 8th October 1985.
28. Wilson, F. (1983) What is to be Done About Violence Against Women? Penguin; The Guardian 9th July 1983.
29. Excum, W. (1986) "Review of Crime, Madness and Politics in Modern France: The Medical Concept of National Decline by Robert A. Nye" in American Journal of Sociology Vol. 91 No. 2 September 1986 p.468.
30. Report by the Research and Advisory Group on the Long-Term Prison System, (no date) Special Units for Long-Term Prisoners: Regimes, Management and Research. Home Office; The Guardian 14th January 1988; Williams, M. and Longley, D. (1986) Identifying Control Problem Prisoners in Dispersal Prisons. Paper presented at 18th Cropwood Conference on Long-Term Imprisonment University of Cambridge 19-21 March 1986.
31. Donnelly, M. op. cit. p.20.

Bibliography.

Primary Sources

Medical Journals

Association Medical Journal

British and Foreign Medico - Chirurgical Review

British Medical Journal

The Lancet

The Medical Directory

Medical Times and Gazette

Prison Medical Journal

Transactions of the Medico-Legal Society

Public Record Office Kew Gardens

P.Com. 2-293

P.Com. 2354

P.Com. 2-165

P.Com. 7331

P.Com. 7326 1922

P.Com. 7318

P.Com. 7326

P.Com. 7740 9670

P.Com. 9192

P.Com. 931

H.O. 45 9450/69228

H.O. 45 9371/38263

H.O. 14453 899 40 (1879-80)

H.O. 45 9471 79161

H.O. 45110 34 A53933 Doc10

H.O. 45 18366 122929/7

H.O. 45 18366 122939/14

H.O. 45 11135

**Newspapers**

Daily Mail

Daily Mirror

Daily Telegraph

The Guardian

The Independent

Liverpool Daily Post

Milton Keynes Citizen

News of the World

The Observer

The Sun

The Times

**Magazines**

Prison Officers' Association Magazine

Searchlight

**Inquest Transcripts**

Coroner's Court Birmingham: Notes of Evidence in the Inquest on Barry Dennis Prosser before Dr. Richard Michael Whittington H.M. Coroner 7th April 1981

Coroner for Inner South District, Greater London H.M. Coroner's Court Tennis Street Southwark. Inquest Transcript on Paul Barrington Worrell

**Parliamentary Papers**

Hansard: House of Commons

Hansard: House of Lords

Parliamentary Reports: Vol. 3 1812



Parliamentary Debates: Vol.28 1814; Vol.33 1816, 1822

Parliamentary Papers 1823-4

British Parliamentary Papers: Vol.6 1863

Observations in Parliamentary Debates: 26 Vic. Vol.169 1863

## Official Publications

### Nineteenth Century

Rules and Regulations of the General Penitentiary at Millbank  
4th March 1817

First Report of the Inspectors of Prisons 1836

Second Report of the Inspectors of Prisons 1837

Seventh Report of the Inspectors of Prisons 1842

Further Papers with Reference to the Inquiry Respecting the  
Treatment of Prisoners in the House of Correction, Knutsford 1843

Copy of the Report Made and Evidence Taken by the Commissioners  
Appointed to Inquire into the Circumstances of the Death of  
John Nolan, Clerkenwell Prison 1879

Report of the Inspectors of Millbank Prison for the Year 1849

Reports of the Directors of Convict Prison for the Years 1857; 1863-66

Return of Prisoners Who Have Received Punishment in Millbank Prison  
in the Year 1863

Statement by the Prison Commissioners of the Action which has been  
taken up to January 1898 to carry out the Recommendations in the  
Report of the Departmental Committee on Prisons 1895

### Twentieth Century

Reports of the Commissioners of Prisons and Directors of Convict  
Prisons 1945-50

Reports of the Commissioners of Prisons 1951-1963

Prisons and Borstals 1950, H.M.S.O.

Reports on the Work of the Prison Department 1964; 1967; 1970-80;  
1984/5

Prison Statistics England and Wales 1970-1984.

Prison Rules 1964 as amended by the Prison (Amendment) Rules of 1968; 1971; 1972; 1974; 1976 and 1981.

Prison Standing Orders June 1981.

Circular Instruction No.20 1977; No.29 1981.

Report of H.M. Chief Inspector of Prisons 1982.

Reports by H.M. Chief Inspector of Prisons on prisons at Gloucester; Durham; Birmingham; Norwich; Nottingham; Ashford; Featherstone.

H.M. Prison Holloway: Purpose and Regime DDG/77/184/177/3.

Civil Service Year Book 1986.

Prison Service News.

### Books and Articles

The Abolitionist Nos. 9 1981; 16 1984; 17 1984; 18 1985; 19 1985; 20 1985; 22 1986; 23 1987.

Abrams, P. (1982) Historical Sociology Open Books.

Abse, L. (1973) Private Member MacDonald.

Adams, P. and Cooklin, S. (1982) Knockback Ariel.

Aikin, J. (1772) A View of the Character and Public Services of the Late John Howard J. Johnson.

Alexander, J. (1984) Review of Protective Equipment for the Prison Service H.M. Prison Service Library Wakefield.

Allen, H. (1987) Justice Unbalanced Open University Press.

Anderson, R.D. (1878) The Prison Acts 1877 and 1865 Sham and Sons.

Atholl, J. (1953) Prison on the Moor John Long.

Baker, P. (1962) Time Out of Life The Windmill Press.

Baly, W. (1845) "On the Mortality in Prisons and the Diseases Most Frequently Fated to Prisoners" in Medico - Chirurgical Transactions Vol.XXVIII Longman, Brown, Green and Longman pp.1-272.

Benn, M. "Women in Prison: Breaking the Silence" in Spare Rib December 1983 pp.51-5.

Benn, M. and Tchaikovsky, C. (1983) "Women Behind Bars" in New Statesman 9th December 1983 pp.8-10.

Benney, M. (1948) Gaol Delivery Longmans, Green and Co.

Beresford, D. (1987) Ten Men Dead Grafton.

Birkinshaw, P. (1981) "The Control Unit Regime: Law and Order in Prisons" in Howard Journal Vol.XX 1981 pp.69-80.

Black Health Workers and Patients Group, (1983) "Psychiatry and the Corporate State" in Race and Class Vol.XXV Autumn 1983 pp.50-64.

Blacker, C. P. (ed) (1937) A Social Problem Group? Oxford University Press.

Bowden, T. (1978) "Ethical Aspects of the Role of Medical Officers in Prison" in Medical Services for Prisoners: Report of a Day Conference held by the Howard League for Penal Reform King's Fund Centre pp.26-47.

Box, S. (1983) Power, Crime and Mystification Tavistock.

Box, S. and Hale, C. (1982) "Economic Crisis and the Rising Prisoner Population in England and Wales" in Crime and Social Justice No.17 September 1982.

Boyle, J. (1977) A Sense of Freedom Pan.

Brophy, J. and Smart, C. (eds) (1985) Women in Law R.K.P.

Burke, P. (1980) Sociology and History Allen and Unwin.

Buxton, J. and Turner, M. (1962) Gate Fever The Cresset Press.

Calder, W. (1955) "The Sexual Offender: A Prison Medical Officer's Viewpoint" in British Journal of Delinquency July 1955 pp.26-40.

Calhoun, C. (1982) The Question of Class Struggle Basil Blackwell.

Calvert, E.R. and Calvert, T. (1933) The Lawbreaker George Routledge and Sons.

Cameron, I. (1984) "Life in the Balance: The Case of Frank Marritt" in Scraton, P. and Gordon, P. (eds) (1984) Causes for Concern Penguin pp.256-272.

Camp, J. (1974) Holloway Prison: The Place and the People David and Charles.

Campbell, B. (1984) Wigan Pier Revisited Virago.

Campbell, J. (1884) Thirty Years Experience of a Medical Officer in the English Convict Service Nelson and Sons.

Campbell, J. (1986) Gate Fever Weidenfeld and Nicolson.

Candy, J. (1985) "The Relationship of the P.M.S. to the N.H.S." in Prison Reform Trust (1985) Submission to the House of Commons Social Services Committee of Inquiry into the Prison Medical Service Prison Reform Trust pp.14-36.

Carlen, P. (1982) "Papa's Discipline: An Analysis of Disciplinary Modes in the Scottish Women's Prison" in Sociological Review Vol.30 No.1 pp.97-124.

Carlen, P. (1983) Women's Imprisonment R.K.P.

Carlen, P. (1985) "Law, Psychiatry and Women's Imprisonment: A Sociological View" in British Journal of Psychiatry, 146, pp.618-21.

Carlen, P. (1986) "Psychiatry in Prisons: Promises, Premises, Practices and Politics" in Miller, P. and Rose, N. (eds) (1986) The Power of Psychiatry Polity Press pp.241-66.

Carlen, P., Hicks, J., O'Dwyer, J., Christina, D., and Tchaikovsky, C. (1985) Criminal Women Polity Press.

Carlen, P. and Worrall, A. (1987) "Introduction: Gender, Crime and Justice" in Carlen, P. and Worrall, A. (1987) Gender, Crime and Justice Open University Press pp.1-14.

Centre for Contemporary Cultural Studies, (1982) The Empire Strikes Back Hutchinson.

Clarke, J. (1985) "Managing the Delinquent: The Children's Branch of the Home Office 1913-30" in Langan, M. and Schwarz, B. (eds) (1985) Crises in the British State 1880-1930 Hutchinson pp.240-55.

Clarke, J., Hall, S., Jefferson, T., and Roberts, B., (1979) "Subcultures, Cultures and Class" in Hall, S. and Jefferson, T. (eds) (1979) Resistance Through Rituals Hutchinson pp.9-74.

Clayton, G.F. (1958) The Wall is Strong John Long.

Coggan, G. and Walker, M. (1982) Frightened for My Life: An Account of Deaths in British Prisons Fontana.

Cohen, D. (no date) Broadmoor Psychology Press News.

Cohen, S. (1972) Folk Devils and Moral Panics MacGibbon and Kee.

Cohen, S. (1985) Visions of Social Control Polity Press.

Cohen, S. and Taylor, L. (1972) Psychological Survival Penguin 1st edition.

Cohen, S. and Taylor, L. (1981) Psychological Survival Penguin 2nd edition.

Cohen, S. and Taylor, L. (1978) Prison Secrets R.A.P./N.C.C.L.

Cohn-Bendit, D. (1968) Obsolete Communism: The Left Wing Alternative Andre Deutsch.

Collins, H. (1984) Marxism and Law Oxford University Press.

Connell, R.W. (1987) Gender and Power Polity Press.

Cooper, D. (1973) "Straw in the Wind" in Prison Medical Journal Summer 1973 pp.19-27.

Cooter, R. (1979) "The Power of the Body: The Early Nineteenth Century" in Barnes, B. and Shapin, S. (eds) (1979) Natural Order: Historical Studies in Scientific Culture Sage pp.73-92.

Corrigan, P. (1977) State Formation and Moral Regulation in Nineteenth Century Britain: Sociological Investigations Unpublished Ph.D. Thesis University of Durham.

Corrigan, P. and Sayer, D. (1985) The Great Arch Basil Blackwell.

Cousins, M. and Hussain, A. (1984) Michel Foucault MacMillan.

Craib, I. (1984) Modern Social Theory Wheatsheaf.

Currie, F.P. (no date) Managing the Minds of Men: The Reformatory Movement 1865-1920 Unpublished Ph.D. Dissertation, Department of Sociology, University of California, Berkeley.

Davis, J. (1980) "The London Garotting Panic of 1862: A Moral Panic and the Creation of a Criminal Class in Mid-Victorian England" in Gatrell, V., Lenman, B. and Parker, G. (eds) (1980) Crime and the Law Europa pp.190-213.

Davis, A. (1971) If They Come in the Morning New American Library.

De Sousa Santos, B. (1985) "On Modes of Production of Law and Social Power" in International Journal of the Sociology of Law Vol.13 1985 pp.299-336.

Dobash, R., Dobash, R.E., and Gutteridge, S. (1986) The Imprisonment of Women Basil Blackwell.

Donnelly, M. (1986) "Foucault's Genealogy of the Human Sciences" in Gane, M. (ed) (1986) Towards A Critique of Foucault R.K.P. pp.15-32.

Doyal, L. and Pennell, I. (1979) The Political Economy of Health Pluto.

East, W.N. (1921) "A Case of Moral Imbecility" in The Lancet 19th November 1921 pp.1052-6.

Eastlea, B. (1981) Science and Sexual Oppression Weidenfeld and Nicolson.

Edwards, S. (1984) Women on Trial Manchester University Press.

Elkin, W. (1957) The English Penal System Pelican.

Epps, P. (1951) "A Preliminary Survey of 300 Female Delinquents in Borstal Institutions" in British Journal of Delinquency Vol.1 January 1951 pp.181-97.

Epps, P. (1954) "A Further Survey of Female Delinquents Undergoing Borstal Training" in British Journal of Delinquency Vol.4 Part 4 1954 pp.265-71.

Epps, P. and Parnell, R.W. (1952) "Physique and Temperament of Women Delinquents Compared with Women Undergraduates" in British Journal of Medical Psychology Vol.XXV Part 4 pp.249-55.

Exum, W. (1986) "Review of Crime, Madness and Politics in Modern France: The Medical Concept of National Decline by Robert A. Nye" in American Journal of Sociology Vol.91 No.2 September 1986 pp.468-70.

Farrall, L.A. (1979) "The History of Eugenics: A Bibliographical Review" in Annals of Science 36, 1979 pp.111-23.

Femia, J. (1987) Gramsci's Political Thought Clarendon Press.

Field, X. (1963) Under Lock and Key Mave Pamish and Co.

Figlio, K. (1978) "Chlorosis and Chronic Disease in 19th Century Britain: The Social Construction of Somatic Illness in a Capitalist Society" in International Journal of Health Services Vol. 8. No.4 1978 pp.589-617.

Fitzgerald, M. (1977) Prisoners in Revolt Penguin.

Fitzgerald, M. and Sim, J. (1979) British Prisons Basil Blackwell 1st edition.

Fitzgerald, M. and Sim, J. (1982) British Prisons Basil Blackwell 2nd edition.

Fletcher, S.W. (1884) Twelve Months in an English Prison Lee and Shepard.

Foot, P. (1986) Murder at the Farm Sidgwick and Jackson.

Forbes, T.R. (1977) "A Mortality Record for Colbath Fields" in Bulletin of New York Academy of Medicine Vol.53 No.7 September 1977 pp.666-70.

Foucault, M. (1977) Discipline and Punish Allen Lane.

Foucault, M. (1983) "Power, Sovereignty and Discipline" in Held, D. et. al. (eds) (1983) States and Societies Martin Robertson pp.306-13.

Fox, L. (1952) The English Prison and Borstal Systems R.K.P.

Fox, L. (1960) "The Prison Service Since the War" in Prison Service Journal Part 1 July 1960 pp.4-14.

Fox, R. Hingston (1919) John Fothergill and His Friends: Chapters in 18th Century Life MacMillan and Co.

Fraser, D. (1973) The Evolution of the British Welfare State MacMillan.

Garland, D. (1981) "The Birth of the Welfare Sanction" in British Journal of Law and Society Vol.8 No.1 pp.29-45.

Garland, D. (1985) Punishment and Welfare Gower.

Garland, D. (1985) "Politics and Policy in Criminological Discourse: A Study in Tendentious Reasoning and Rhetoric" in International Journal of the Sociology of Law Vol.13 No.1 February 1985 pp.1-33.

Garland, D. (1988) "British Criminology Before 1935" in Rock, P. (ed) (1988) A History of British Criminology: British Journal of Criminology Vol.28 No.2 Spring 1988 pp.1-17.

Gatrell, V. (1980) "The Decline of Theft and Violence in Victorian and Edwardian England" in Gatrell, V., Lenman, B., and Parker, G. (eds) (1980) Crime and the Law Europa pp.238-370.

Geary, R. (1980) Deaths in Prison N.C.C.L.

Genders, E. And Player, E. (1987) "Women in Prison: The Treatment, the Control and the Experience" in Carlen, P. and Worrall, A. (eds) (1987) Gender, Crime and Justice Open University Press pp.161-75.

Gibbens, T.C.N., Soothill, K.L., and Pope, P.J. (1977) Medical Remands in the Criminal Court Oxford University Press/ Institute of Psychiatry Maudsley Monographs No.25.

Gilroy, P. (1987) There Ain't No Black in the Union Jack Hutchinson.

Godfrey, C. (1979) "The Chartist Prisoners 1839-41" in International Review of Social History Vol.XXIV Part 2 1979 pp.189-236.

Good, J.M. (1795) A Dissertation on the Diseases of Prisons and Workhouses C. Dilly.

Gordon, E. (1983) "Women, Trade Unions and Industrial Militancy 1850-1890" in Glasgow Women's Studies Group (eds) (1983) Unchartered Lives Pressgang pp.52-73.

Gordon, M. (1922) Penal Discipline R.K.P.

Gordon, P. (1983) Whitelaw Pluto.

The Government's Reply to the Third Report from the Social Services Committee Session 1985-86 HMSO.

Gramsci, A. (1985) Selections From Cultural Writings Lawrence and Wishart.

Greater London Council Ethnic Minorities Unit Policy Report, (1985) Local Authorities and Penal Establishments: A Race Dimension Greater London Council.

Greater London Council Women's Committee, (1986) Breaking the Silence London Strategic Policy Unit.

Griffiths, A. (1875) Memorials of Millbank and Chapters in Prison History 2 Volumes Henry S. King.

Griffiths, A. (1884) Memorials of Millbank and Chapters in Prison History Chapman and Hall.

Griffiths, A. (1905) Fifty Years of Public Service Cassell and Company.

Gunn, J., Robertson, G., Dell, S., and Way, C. (1978) Psychiatric Aspects of Imprisonment Academic Press.

Gurney, J.J. (1819) Notes on a Visit Made to Some of the Prisons in Scotland and the North of England Archibald and Constable and Co.

Guy, W. (1884) A Third Contribution to a Knowledge of the Influence of Employment upon Health Wellcome Institute for the History of Medicine Pamphlet No.1.

Guy, W. (1846-7) "On Medical Education: Being a Lecture Delivered at Opening of the Medical Session 1846-7" in Aberdeen M-CS Tracts 8TP 44A 25 Wellcome Institute for the History of Medicine.

Guy, W. (1848) "The Case of the Journeymen Bakers: Being a Lecture on the Evils of Night Work and Long Hours of Labour" in Wellcome Institute File T508.

Guy, W. (1863) "On Sufficient and Insufficient Dietaries with Especial Reference to the Dietaries of Prisoners" in Journal of the Statistical Society Vol.XXVI pp.239-280.

Guy, W. (1882) John Howard's Winter's Journey Thos. De La Rue Co.

Hall, S. (1985) "Authoritarian Populism: A Reply to Jessop et. al." in New Left Review May/June 1985 pp.115-24.

Hall, S., Critcher, C., Jefferson, T., Clarke, J. and Roberts, B. (1978) Policing the Crisis MacMillan.

Hall, S. and Scraton, P. (1981) "Law, Class and Control" in Fitzgerald, M., McLennan, G., and Pawson, J. (compilers) (1981) Crime and Society R.K.P. pp.460-97.

Hall, S. and Schwarz, B. (1985) "State and Society 1880-1930" in Langan, M. and Schwarz, B. (eds) (1985) Crises in the British State 1880-1930 Hutchinson pp.7-32.

Harrison, R. and Mort, F. (1980) "Patriarchal Aspects of Nineteenth Century State Formation" in Corrigan, P. (ed) (1980) Capitalism, State Formation and Marxist Theory Quartet pp.79-109.

Heidensohn, F. (1980) Women and the Penal System Paper presented at the Cropwood Round-Table Conference on Women and Crime. University of Cambridge 1980.

Heidensohn, F. (1985) Women and Crime MacMillan.



Henriques, U. (1979) Before the Welfare State Longmans.

Henry, J. (1952) Women in Prison Doubleday.

Her Majesty's Prison Holloway: Purpose and Regime. PDG177/84/177/3. Her Majesty's Prison Service Staff College Library, Wakefield.

Higman, D.W. (1984) North Region Training Programme 1984-5. Her Majesty's Prison Service Staff College Library, Wakefield.

Hillyard, P. (1983) "Law and Order" in Darby, J. (ed) (1983) Northern Ireland: Background to Conflict Appletree Press pp.32-60.

Hinde, R.S.F. (1951) The English Penal System 1773-1950 Gerald Duckworth and Co. Ltd.

Hobhouse, S. and Brockway, A.F. (1922) English Prisons Today Longmans.

Home Office, (1946) The New Post of Medical Adviser to the Home Office 141/1946.

Home Office, (1969) People in Prison: England and Wales HMSO.

Home Office, (1977) Prisons and the Prisoner HMSO.

Home Office, (1975) "The Prison Medical Service England and Wales" in Inquiry into the U.K. Prison Services Vol.II Evidence by the Home Office, the Scottish Home and Health Department and the Northern Ireland Office HMSO pp.213-22.

Home Office, (1984) Managing the Long-Term Prison System HMSO.

Home Office, (no date) The Prisons and Borstal Nursing Service The Home Office.

Home Office, (no date) Inside Hospital Care: The Prison Hospital Officer The Home Office.

House of Commons Social Services Committee (1986) Third Report Session 1985-86 Prison Medical Service Vol.1 Report Together with the Proceedings of the Committee HMSO.

House of Commons Social Services Committee (1986) Third Report Session 1985-6 Prison Medical Service Vol.2 Minutes of Evidence and Appendices HMSO.

Howard, D.L. (1960) The English Prisons Butler and Tanner.

Howard Journal Vol.XVIII No.3 1979.

Hudson, D. (1987) "You Can't Commit Violence Against An Object: Women, Psychiatry and Psychosurgery" in Hanmer, J. and Maynard, M. (eds) (1987) Women, Violence and Social Control MacMillan pp.110-21.

Hughes, R. (1987) The Fatal Shore Guild.

Humphries, S. (1981) Hooligans or Rebels? : An Oral History of Working Class Childhood Basil Blackwell.

Hunt, A. (1978) The Sociological Movement in Law MacMillan.

Ignatieff, M. (1978) A Just Measure of Pain MacMillan.

Ignatieff, M. (1981) "State, Civil Society and Total Institutions: A Critique of Recent Social Theories of Punishment" Unpublished draft of paper which appeared in Crime and Society No.6.

Ignatieff, M. (1983) "State, Civil Society and Total Institutions: A Critique of Recent Social Histories of Punishment" in Cohen, S. and Scull, A. (eds) (1983) Social Control and the State Martin Robertson pp.75-105.

Ingleby, D. (1983) "Mental Health and Social Order" in Cohen, S. and Scull, A. (eds) (1983) Social Control and the State Martin Robertson pp.141-88.

Irwin, J. and Cressey, D. (1962) "Thieves, Convicts and the Inmate Culture" in Social Problems No.10 pp.142-55.

Jones, A.E. (1945) Juvenile Delinquency and the Law Penguin.

Jones, H. (1956) Crime and the Penal System University Tutorial Press.

Jones, H. (1965) Crime in a Changing Society Penguin.

Jones, G. Stedman (1971) Outcast London Clarendon Press.

Kaye, H. (1984) The British Marxist Historians Polity Press.

Kee, R. (1986) Trial and Error Hamish Hamilton.

Keeley, F. (1979) "The Home Office and the Liquid Cosh" in The Abolitionist January 1979 pp.6-8.

Kelley, J. (1957) "Some Aspects of the Work at Askham Grange Open Prison for Women" in Journal of the Medical Women's Federation July 1957 pp.195-8.

Kelley, J. (1967) When the Gate Shuts Longmans, Green and Co.

Kemp, D. (1983) "Prisoners and the Mental Health Act in Prison Service Journal July 1983 pp.5-8.

Kennedy, L. (1988) "Review of Criminal Justice: The True Story of Edith Thompson by Rene Weis" in The Observer 17th July 1988.

King, R. (1985) "Control in Prisons" in Maguire, M., Vagg, J. and Morgan, R. (eds) (1985) Accountability and Prisons Tavistock.

King, R. and Morgan, R. (1976) A Taste of Prison R.K.P.

King, R. and Morgan, R. (1980) The Future of the Prison System Gower.

Krohn, M. (1986) "The Web of Conformity: A Network Approach to the Explanation of Deviant Behaviour" in Social Problems Vol.33 No.6 December 1986 pp.558-60.

Latham, P. (1825) An Account of the Diseases Lately Prevalent at the General Penitentiary Thomas and George Underwood.

Laycock, G. (1983) "' Highly Dangerous' Prisoners" in Home Office Research and Planning Unit Research Bulletin No.15 pp.32-5.

Lee, B. (1983) "Free the Prison Doctors Now" in World Medicine 6th August 1983 pp.20-1.

Leggett, B. (1980) "Drugs in Prison" in Probe Autumn 1980 pp.5-9.

Leigh, D. (1980) The Frontiers of Secrecy Junction.

Lettsom, J. (1786) Memoirs of John Fothergill Dilly.

Linebaugh, P. (1977) "The Tyburn Riot Against the Surgeons" in Hay, D., Linebaugh, P., Thompson, E.P. and Winslow, C. (eds) (1977) Albion's Fatal Tree Peregrine pp.65-118.

Liverpool South West Lancashire and Wirral Discharged Prisoners' Aid Society, (1924) H.M. Prison Liverpool Annual Reports 1913-23 The Gainsboro Press.

Lloyd, R. and Williamson, S. (1968) Born to Trouble Cassirer.

Lorimar, D. (1975) Colour, Class and the Victorians Leicester University Press.

Lukes, S. (ed) (1986) Power Basil Blackwell.

Lytton, C. (1976) Prisons and Prisoners: Experiences of a Suffragette E.P. Publishing.

MacCartney, W.C. (1936) Walls Have Mouths Victor Gollancz.

Mackeith, J.A.C. (1978) "Practical Constraints of the Work of the Prison Medical Officer" in Medical Services for Prisoners: Report of a Day Conference held by the Howard League for Penal Reform King's Fund Centre pp.47-56.

Mackenzie, D. (1976) "Eugenics in Britain" in Social Studies of Science 6, 1976 pp.499-532.

Mackenzie, D. (1979) "Karl Pearson and the Professional Middle Class" in Annals of Science 36, pp.125-43.

Mackinnon, C.A. (1987) "Feminism, Marxism, Method and the State: Towards Feminist Jurisprudence" in Harding, S. (ed) (1987) Feminism and Methodology Open University Press pp.135-56.

MacLaughlin, R. (1987) Inside An English Jail Borderline.

McConville, S. (1981) A History of English Prison Administration  
Vol.1 1750-1877 R.K.P.

McGovern, D. and Cope, R. (1987) "The Compulsory Detention of  
Males of Different Ethnic Groups with Special Reference to  
Offender Patients" in British Journal of Psychiatry No.150  
1987 pp.505-12.

McGrath, R. (1984) "Medical Police" in Ten 8: Quarterly Photographic  
Journal No.14 pp.13-18.

Maguire, M., Vagg, J., and Morgan, R. (eds) (1985) Accountability  
and Prisons Tavistock.

Mandaraka-Sheppard, A. (1986) The Dynamics of Aggression in  
Women's Prisons in England Gower.

Mannheim, H. (1946) Criminal Justice and Social Reconstruction  
R.K.P.

Marcus, B. (1958) "A Dimensional Study of a Prison Population"  
Psychological Monograph No.2 Office of Chief Psychologist Prison  
Commission December 1958.

Mathiesen, T. (1974) The Politics of Abolition Martin Robertson.

Matthews, J. (1980) Women and the Penal System NACRO.

Maybrick, F.E. (1905) Mrs Maybrick's Own Story: My Fifteen Lost  
Years Funk and Wagnalls Company.

Melossi, D. and Pavarini, M. (1981) The Prison and the Factory  
MacMillan.

Memorandum Submitted by Prison Medical Officers to the Royal  
Commission on the Penal System (no date) H.M. Prison Service  
College Library Wakefield.

Mercer, C. (1980) "Revolutions, Reforms or Reformulations?  
Marxist Discourse on Democracy" in Hunt, A. (ed) (1980) Marxism  
and Democracy Lawrence and Wishart pp.101-37.

Merchant, A. (1896) Six Years in the Convict Prisons of England  
Richard Bentley.

Michael, J. (1982) The Politics of Secrecy Penguin.

Miller, A. (1976) Inside Outside Queensgate.

Miller, P. and Rose, N. (1988) "The Tavistock Programme: The  
Government of Subjectivity and Social Life" in Sociology Vol.22  
No.2 May 1988 pp.171-92.

Mills, C.W. (1959) The Sociological Imagination Oxford University  
Press.

Minutes of the Regional Conference of Governors held at Haverigg Prison 10th June 1969 H.M. Prison Service College Library Wakefield.

Morel, J. (1892) "The Psychological Examination of Prisoners" in Journal of Mental Science Vol.39 pp.12-16.

Moorhead, C. (1985) "The Strange Events at Holloway" in New Society 11th April 1985 pp.40-2.

Morgan, A.M. (1964) "Women in Preventive Detention" in Prison Service Journal Vol.4 Part 13 October 1964 pp.11-25.

Morgan, K. (1985) Labour in Power 1945-51 Oxford University Press.

Morris, A. (1987) Women, Crime and Criminal Justice Basil Blackwell.

Morris, T., Morris, P. and Biely, B. (1961) Unpublished Report on the Prison Community Research Project 1958-61 H.M. Prison Service College Library Wakefield.

Morris, T. and Morris, P. (1963) Pentonville R.K.P.

Mort, F. (1987) Dangerous Sexualities R.K.P.

Mullin, C. (1986) Error of Judgement Chatto and Windus.

National Association for the Care and Resettlement of Offenders (1986) The Prison Medical Service NACRO.

Nellis, M. and Hale, C. (1982) The Prison Film RAP.

Newsline (no date) Britain's State within the State New Park Publications.

New Statesman 5th July 1985.

Oakley, A. (1982) Subject Women Fontana.

One Who Has Endured it, (1877) Five Years Penal Servitude Richard Bentley.

One Who Has Tried Them, (1881) Her Majesty's Prisons, Their Effects and Defects Vol.2 Sampson Low, Marston, Searle and Revington.

Open Space, (1984) "The Women of Durham Jail" Transcript February 1984.

Owen, T. (1979) Medical Treatment in Prisons Unpublished Paper.

Owen, T. (1980) The Use of Behaviour Modifying Drugs in British Prisons: An Analysis of the Medical Statistics Published in the 1979 Report on the Work of the Prison Department RAP Briefing.

Owen, T. and Sim, J. (1984) "Drugs, Discipline and Prison Medicine: The Case of George Wilkinson" in Scraton, P. and Gordon, P. (eds) (1984) Causes for Concern Pelican pp.228-55.

Padel, U. and Stevenson, P. (1988) Insiders Virago.

Pallas, J. and Barber, B. (1980) "From Riot to Revolution" in Platt, T. and Takagi, P. (eds) (1980) Punishment and Penal Discipline Crime and Social Justice pp.146-54.

Panitch, L. (1986) Working Class Politics in Crisis Verso.

Parker, T. and Allerton, R. (1962) The Courage of His Convictions Hutchinson.

Partnow, E. (ed) (1978) The Quotable Woman Anchor.

Patton, P. (1979) "Of Power and Prisons" in Morris, M. and Patton, P. (eds) (1979) Michel Foucault: Power, Truth and Strategy Ferrall Publishers pp.109-47.

Pearson, G. (1983) Hooligan: A History of Respectable Fears MacMillan.

Peckham, A. (1985) "Passing Through Purgatory" in New Statesman 21st June 1985 pp.23-5.

Pellow, J. (1982) The Home Office 1848-1914: From Clerks to Bureaucrats Heinemann.

Philips, D. (1980) "A New Engine of Power and Authority: The Institutionalisation of Law Enforcement in England" in Gatrell V. Lenman, B. and Parker, G. (eds) (1980) Crime and the Law Europa pp.155-189.

Piven, F.F. and Cloward, R. (1979) Poor People's Movements Vintage.

Plotnikoff, J. (1986) Prison Rules: A Working Guide The Prison Reform Trust.

Ponting, C. (1986) Whitehall: Tragedy and Farce Sphere.

Poulantzas, N. (1978) State, Power, Socialism Verso.

Prewer, R.R. (1974) "Prison Medicine" in Blom Cooper, L. (ed) (1974) Progress in Penal Reform Oxford University Press pp.116-28.

Priestley, P. (1985) Victorian Prison Lives Methuen.

Prison Matron, (1864) Female Life in Prison Sampson, Low Son and Marston.

Prison Medical Reform Council (1943a) Prison Medical Service Prison Medical Reform Council(P.M.R.C.)

Prison Medical Reform Council (1943b) Prisoners' Circle P.M.R.C.

Prison Medical Reform Council (1943c) Prison for Women: Some Accounts of Life in Holloway P.M.R.C.

Prison Medical Reform Council (1944) Prisoners' Medical Charter P.M.R.C.

Prison Medical Reform Council (1945) The Case of Prisoner Alpha P.M.R.C.

Prison Reform Council (1962) Inside Story Prison Reform Council.

Prison Reform Trust (1984) Beyond Restraint Prison Reform Trust.

Prison Reform Trust (1984) Parliamentary All-Party Penal Affairs Group: Working Party on Life Sentence Prisoners Submission by Prison Reform Trust.

Prison Reform Trust (1985) House of Commons Social Services Committee of Inquiry into the Prison Medical Service Submission by Prison Reform Trust.

Probe May 1979.

Probyn, W. (1977) Angel Face: The Making of a Criminal George Allen and Unwin.

PROP (no date) Don't Mark His Face PROP.

"Psychiatry in Prisons and Corrective Institutions" in Proceedings of the Royal Society of Medicine Vol.XLVIII 1954.

Quinton, R.F. (1910) Crime and Criminals Longmans Green.

Rabinow, P. (ed) (1984) The Foucault Reader Peregrine.

Radzinowicz, L. and Hood, R. (1979) "The Status of Political Prisoners in England: The Struggle for Recognition" in Virginia Law Review Vol.65 No.8 pp.1421-81.

Read, P.P. (1978) The Train Robbers W.H. Allen.

Red Collar Man (1937) Chokey Victor Gollancz.

Reid, P. (1984) Colditz: The Full Story MacMillan.

Report of the Independent Committee of Inquiry (1987) The Roof Comes Off The Gateway Exchange.

Report by the Research and Advisory Group on the Long-Term Prison System (no date) Special Units for Long-Term Prisoners: Regimes, Management and Research Home Office.

Rich, C.E.F. (1932) Recollections of a Prison Governor Hurst and Blackett.

Richmond, G. (1975) Prison Doctor Nunaga Publishing.

Rose, J. (1980) Elizabeth Fry MacMillan.

Rose, N. (1985) The Psychological Complex R.K.P.

Rose, S., Kamin, L. and Lewontin, R. (1984) Not In Our Genes Penguin.

Rosen, G. (1973) "Health, History and the Social Sciences" in Social Science and Medicine 1973 Vol.7 No.4 pp.233-48.

Rowett, C. and Vaughan, P. (1981) "Women and Broadmoor: Treatment and Control in a Special Hospital" in Hutter, B. and Williams, G. (eds) (1981) Controlling Women Croom-Helm pp.131-53.

Royal College of Psychiatrists, (1979) "The College's Evidence to the Prison Service's Inquiry" in Bulletin of the Royal College of Psychiatrists May 1979 pp.81-4.

Royal College of Psychiatrists (no date) Evidence to the Inquiry into the U.K. Prison Services Document E.F.C.C. 73/78.

Rusche, G. and Kirkheimer, O. (1939) Punishment and Social Structure Columbia University Press.

Rutherford, A. (1983) Prisons and the Process of Justice Heinemann.

Rutter, M. (1972) Maternal Deprivation Re-assessed Penguin.

Ryan, M. (1983) The Politics of Penal Reform Longman.

Samuel, R. (1981) East End Underworld R.K.P.

Sands, B. (1983) One Day in My Life Pluto.

Sassoon, A. Showstack (ed) (1987) Women and the State Hutchinson.

Saunders, J. (1981) "Magistrates and Madmen: Segregating the Criminally Insane in Late Nineteenth Century Warwickshire" in Bailey, V. (ed) (1981) Policing and Punishment in Nineteenth Century Britain Croom Helm, pp.217-41.

Schrag, P. (1980) Mind Control Marion Boyars.

Scruton, P. (1985) The State of the Police Pluto.

Scruton, P. (1985) "The State vs. the People: An Introduction" in Scruton, P. and Thomas, P. (eds) (1985) The State vs. The People Basil Blackwell, pp.251-66.

Scruton, P. and Chadwick, K. (1987) In the Arms of the Law Pluto.

Scull, A. (1982) Museums of Madness Penguin.

Searchlight No.109 July 1984.

Sedgwick, P. (1982) Psycho Politics Pluto.



Senn, R.C. Ingreys (1978) "Prison Medicine" in Medical Services for Prisoners: Report of a Day Conference held by the Howard League for Penal Reform King's Fund Centre, pp.1-13.

Shaw, C. (1987) "Prison Medicine" in Open Mind April/May 1987 p.15.

Shaw, C. (1985) "Introduction: The Case for Change in the Prison Medical Service" in Prison Reform Trust (1985) Prison Medicine: Ideas on Health Care in Penal Establishments Prison Reform Trust pp.1-12.

Showalter, E. (1987) The Female Malady Virago.

Sim, J. (1981) "Women in Prison: A Historical View" in The Abolitionist No.8 Spring 1981, pp.14-18.

Sim, J. (1986) "Watching the Prison Wheels Grind: The 1985 Report of H.M. Chief Inspector of Prisons" in The Abolitionist No.21 1986 pp.6-9.

Sim, J. (1987) "Working for the Clampdown: Prisons and Politics in England and Wales" in Scraton, P. (ed) (1987) Law, Order and the Authoritarian State Open University Press, pp.190-211.

Sim, J., Scraton, P. and Gordon, P. (1987) "Crime, the State and Critical Analysis" in Scraton, P. (ed) (1987) Law, Order and the Authoritarian State Open University Press, pp.1-70.

Simon, J. (1974) "Michel Foucault on Attica: An Interview" in Telos Part 19, Spring 1974, pp.154-61.

Simmons, H. (1978) "Explaining Social Policy: The English Mental Deficiency Act of 1913" in Journal of Social History Vol.11 pp.387-403.

Sinn Fein (1980) Irish Political Prisoners in Britain Sinn Fein.

Sivanandan, A. (1982) A Different Hunger Pluto.

Size, M. (1957) Prisons I Have Known Allen and Unwin.

Smart, B. (1976) Sociology, Phenomenology and Marxism R.K.P.

Smart, B. (1985) Michel Foucault Tavistock.

Smart, C. (1976) Women, Crime and Criminology R.K.P.

Smart, C. (1984) The Ties That Bind R.K.P.

Smith, A. (1965) "Penal Policy and the Female Offender" in Halmos, P. (ed) (1965) Sociological Review Monograph No.9, University of Keele, pp.111-32.

Smith, M. Hamblin (1934) Prisons John Lane/The Bodley Head.

Smith, R. (1981) Trial by Medicine Edinburgh University Press.

- Smith, R. (1983) "Organization of Prison Medical Services" in British Medical Journal Vol.287 December 1983 pp.1867-1870.
- Smith, R. (1984) Prison Health Care British Medical Association.
- Snell, H. (1959) "The Prison Medical Service" in Howard Journal Vol.10 No.2 pp.75-86.
- Soyinka, W. (1985) The Man Died Arrow.
- Sparks, R.F. (1966) "The Decision to Remand for Mental Examination" in British Journal of Criminology Vol.6 pp.6-26.
- Spencer, A. and Podmore, D. (eds) (1987) In a Man's World: Essays on Women in Male Dominated Institutions Tavistock.
- Spender, D. (1982) Women of Ideas (And What Men Have Done to Them) ARK.
- Stacey, M. and Price, M. (1981) Women, Power and Politics Tavistock.
- Steinert, H. (1980) "The Development of Discipline According to Michel Foucault: Discourse Analysis vs. Social History" in Crime and Social Justice No.20 pp.83-98.
- Stern, V. (1987) Bricks of Shame Penguin.
- Strank, R.A. (1983) "Nursing Care in Prisons" in Association of Members of Boards of Visitors Quarterly No.9 April 1983 p.8.
- Stratton, B. (1973) Who Guards the Guards? PROP.
- Sullivan, W.C. (1912) "Feeble-Mindedness and the Measurement of Intelligence by the Method of Binet and Simon" in The Lancet 23rd March 1912 pp.777-80.
- Sullivan, W.C. (1921) "Crime and Mental Deficiency" in The Lancet 15th October 1921 pp.787-91.
- Sykes, G. (1958) The Society of Captives Princeton University Press.
- Taussing, M. (1987) Shamanism, Colonialism and the Wild Man: A Study in Terror and Healing University of Chicago Press.
- Taylor, I. (1981) Law and Order: Arguments for Socialism MacMillan.
- Taylor, I., Walton, P. and Young, J. (1973) The New Criminology R.K.P.
- Thomas, E. (1965) The Psychologist in the Prison Service C.P. Report 5th February 1965.
- Thomas, J.E. (1972) The English Prison Officer Since 1850 R.K.P.
- Thomas, J.E. and Pooley, R. (1980) The Exploding Prison Junction.
- Tomlinson, M.H. (1981) "Penal Servitude 1846-65: A System in Evolution" in Bailey, V. (ed) (1981) Policing and Punishment in Nineteenth Century Britain Croom Helm pp.126-49.

Topp, D.O. (1971) "The Doctor in Prison" in Medicine, Science and the Law 17 pp.261-64.

Treacher, A. and Baruch, G. (1981) "Towards a Critical History of the Psychiatric Profession" in Ingleby, D. (ed) (1981) Critical Psychiatry Penguin pp.120-149.

Turner, E.S. (1958) Call the Doctor: A Social History of Medical Men Michael Joseph.

Vick, G.R. (1958) Allegations of Ill-Treatment of Prisoners in H.M. Prison Liverpool HMSO.

Waddington, I. (1977) "General Practitioners and Consultants in Early Nineteenth Century England: The Sociology of an Intra-Professional Conflict" in Woodward, J. and Richards, D. (eds) (1977) Health Care and Popular Medicine in Nineteenth Century England Croom Helm pp.164-88.

Wakefield, D. (1980) A Thousand Days in Solitary PROP.

Walker, N. (1968) Crime and Insanity in England Vol.1 Edinburgh University Press.

Walkowitz, J. (1980) Prostitution and Victorian Society Cambridge University Press.

Ward, T. (1985) "Coroners, Police and Deaths in Custody in England: A Historical Perspective" in European Group for the Study of Deviance and Social Control (1985) The State of Information in 1984 pp.186-215.

Warren, D. (1982) The Key to My Cell New Park Publications.

Watson, S. (1988) The Moral Imbecile: A Study of the Relations Between Penal Practice and Psychiatric Knowledge of the Habitual Offender A Dissertation submitted in Partial Fulfilment of the Degree of Ph.D. University of Lancaster.

Webb, S. and Webb, B (1922) English Prisons Under Local Government Longmans Green and Co.

Weis, R. (1988) Criminal Justice: The True Story of Edith Thompson Hamish Hamilton.

West, D.J. and Bearcroft, J.S. (1960) "The Choice of Bail or Custody for Offenders Remanded for a Psychiatric Report" in International Journal of Social Psychiatry Vol.6 No.34 pp.34-50.

Whitehead, T. (1983) Mental Illness and the Law Basil Blackwell.

Whitehead, T. (1985) "The Use of Psychotropic Drugs in Prison" in Prison Reform Trust, (1985) Prison Medicine: Ideas on Health Care in Penal Establishments Prison Reform Trust pp.71-82.

Whiting, J. (1975) Prison Reform in Gloucestershire Phillimore and Co.

Wicker, T. (1975) A Time to Die The Bodley Head.

Wildeblood, P. (1957) Against the Law Penguin.

Williams, M. and Longley, D. (1986) Identifying Control-Problem Prisoners in Dispersal Prisons Paper presented at the 18th Cropwood Conference on Long-Term Imprisonment, University of Cambridge 19-21 March 1986.

Williams, J.E. Hall (1975) Changing Prisons Peter Owen.

Willis, P. (1977) Learning to Labour Gower.

Wilson, E. (1977) Only Halfway to Paradise Tavistock.

Wilson, E. (1983) What is to be Done About Violence Against Women? Penguin.

Woodside, M. (1962) "Instability of Women Prisoners" in The Lancet 3rd November 1962 pp.928-930.

Wootton, B. (1963) "The Law, the Doctor and the Deviant" in British Medical Journal 27th July 1963 pp.197-202.

World in Action (1982) Prisoners' Medicine Transcript No.568/603, 19th July 1982.

Wright, M. (1982) Making Good Burnett Books.

Young, J. (1971) The Drugtakers Paladin.

Young, P. (1983) "Sociology, the State and Penal Relations" in Garland, D. and Young, P. (eds) (1983) The Power to Punish Heinemann, pp.84-100.